FILED
MAR 12 1981
ALEXANDER L. STEVAS, CLERK

No. 80-802

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Petitioner,

v.

BLUE CROSS OF KANSAS CITY, AND BLUE CROSS ASSOCIATION,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

JOINT APPENDIX

ERWIN N. GRISWOLD
JONES, DAY, REAVIS & POGUE
1735 Eye Street, N.W.
Washington, D.C. 20006
(202) 861-3898
Counsel for Petitioner

HARRY P. THOMPSON, JR.
SHUGHART, THOMPSON & KILROY, P.C.
Ninth Floor Commerce Bank Building
922 Walnut Street
P.O. Box 13007
Kansas City, Missouri 64199
(816) 421-3355
Counsel for Respondent Blue Cross of Kansas City

JOSHUA F. GREENBERG
KAYE, SCHOLER, FIERMAN, HAYS & HANDLER
425 Park Avenue
New York, New York 10022
(212) 759-8400
Counsel for Respondent Blue Cross Association

PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D. C.

Petition for Certiorari Filed November 18, 1980.
Certiorari Granted January 26, 1981.

TABLE OF CONTENTS

	Page
Chronological List of Relevant Docket Entries	1a
Complaint (filed May 23, 1978)	5a
Motion of Blue Cross Association to Dismiss (filed July 14, 1978)	19a
Motion of Blue Cross of Kansas City to Dismiss (filed July 14, 1978)	21a
Affidavit of Donald L. Flora, Attachment to the Motion of Blue Cross Association to Dismiss and Suggestions of Blue Cross Association in Support of Motion to Dismiss (filed July 14, 1978)	25a
Excerpts from the MAHSA Systems Plan, Exhibit A to the Affidavit of Donald L. Flora (filed July 14, 1978)	27a
Affidavit of Jerry B. Buxton, Exhibit A to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	135a
Affidavit of Henry Mandro, Exhibit B to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	139a
Prerequisites for Application for Admission as a Blue Cross Participating Hospital, Exhibit C to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	141a
Newsletter from Blue Cross of Kansas City, Exhibit D to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss (filed Aug. 18, 1978)	147a
Approval Program for Blue Cross Plans, Exhibit B to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital (filed Nov. 28, 1978)	149a

Page

Cost Containment Approval Standard for Blue Cross Plans and Implementing Requirements and Guidelines, Exhibit F to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital (filed Nov. 28, 1978) 159a

Affidavit of David J. Maschger, Exhibit J to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions of National Gerimedical Hospital Opposing Summary Judgment (filed Oct. 22, 1979) 167a

Letter from Gary L. Ihde to National Gerimedical Hospital, Exhibit K to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment (filed Oct. 22, 1979) 169a

Order of the District Court for the Western District of Missouri (entered Nov. 2, 1979) 171a

Opinion of the United States Court of Appeals for the Eighth Circuit (entered July 22, 1980) 199a

Judgment of the United States Court of Appeals for the Eighth Circuit (entered July 22, 1980) 215a

Order denying Petition of National Gerimedical Hospital for Rehearing (entered Aug. 22, 1980) ... 217a

JOINT APPENDIX

Chronological List of Relevant Docket Entries

1978

May 23—Complaint of National Gerimedical Hospital filed.

July 14—Motion of Blue Cross Association to Dismiss filed. Motion of Blue Cross of Kansas City to Dismiss, with exhibits, filed.

Aug. 18—Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss, with exhibits, filed.

Sept. 8—Response of Blue Cross of Kansas City to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss filed.

Oct. 6—First Interrogatories of National Gerimedical Hospital to Blue Cross Association and Blue Cross of Kansas City filed.

Nov. 28—Answers and Objections of Blue Cross Association to First Interrogatories of National Gerimedical Hospital filed.

Dec. 1—First Interrogatories of Blue Cross of Kansas City to National Gerimedical Hospital filed.

Dec. 21—Answers of Blue Cross of Kansas City to First Interrogatories of National Gerimedical Hospital, with exhibits, filed.

1979

Jan. 15—Answers of National Gerimedical Hospital to First Interrogatories of Blue Cross of Kansas City filed.

Mar. 7—Supplemental Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss filed.

Apr. 9—Reply of Blue Cross Association to Supplemental Suggestions of National Gerimedical Hospital in Op-

position to Motions to Dismiss filed. Reply of Blue Cross of Kansas City to Supplemental Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss, with exhibits, filed.

Apr. 23—Second Supplemental Suggestions of National Gerimedical Hospital Opposing Motions to Dismiss filed.

Oct. 11—Order to Show Cause Why Motion to Dismiss Should Not be Treated as One for Summary Judgment entered.

Oct. 22—Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment filed.

Oct. 24—Response of Blue Cross of Kansas City to Order to Show Cause and Reply to Preliminary Response of National Gerimedical Hospital filed.

Nov. 2—Order Granting Summary Judgment for Blue Cross Association and Blue Cross of Kansas City entered.

Nov. 30—Notice of Appeal filed.

Dec. 3—Appeal docketed.

1980

Jan. 29—Brief of National Gerimedical Hospital and Authorities Supplemental to Brief filed.

Jan. 30—Amicus Curiae Brief of Federation of American Hospitals filed.

Feb. 28—Brief of Blue Cross of Kansas City filed.

Feb. 29—Brief of Blue Cross Association filed.

Mar. 26—Brief of Amicus Curiae American Health Planning Association filed.

Mar. 28—Reply Brief of National Gerimedical Hospital filed.

Apr. 15—Oral Argument.

July 22—Opinion and Judgment of the United States Court of Appeals for the Eighth Circuit affirming Judgment of the District Court for the Western District of Missouri entered.

Aug. 15—Petition of National Gerimedical Hospital for Rehearing With Suggestions for Rehearing En Banc filed.

Aug. 22—Petition of National Gerimedical Hospital for Rehearing denied.

IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF MISSOURI, WESTERN DIVISION

Case No. 78-0359-CV-W3

JURY DEMANDED

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
A Missouri Not-for-Profit Corporation,
530 North Murray,
Lee's Summit, Missouri 64063,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY,
A Missouri Corporation,
3637 Broadway,
Kansas City, Missouri 64111,

Serve: Courtney H. Taber,
Registered Agent

and

BLUE CROSS ASSOCIATION,
An Illinois Corporation,
233 North Michigan Avenue,
Chicago, Illinois 60601

Serve: S. Martin Hickman,
President
Defendants.

COMPLAINT

(Filed May 23, 1978)

COMES NOW plaintiff, NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER and for its Complaint against

PREVIOUS PAGE WAS BLANK

BLUE CROSS OF KANSAS CITY and BLUE CROSS ASSOCIATION, defendants, states and shows to the Court as follows:

Jurisdiction and Venue

1. This is a civil antitrust action against defendants pursuant to Sections 4 and 16 of the Clayton Act [15 U.S.C. §§ 15 and 26] and Section 416.121, RSMo. (1975 Supp.) of the Missouri Antitrust Law for treble damages and injunctive relief. This Court has original jurisdiction hereof pursuant to 28 U.S.C. § 1337 and pendent jurisdiction of state law claims herein.

2. The unlawful acts and violations hereinafter alleged have been and are in part conceived, performed, carried out and made effective by defendants and others not now named as parties defendant in the Western District of Missouri, Western Division. The interstate trade and commerce hereinafter described is conducted in part within the Western District of Missouri, Western Division by all parties hereto. Each defendant named herein conducts and transacts business in the Western District of Missouri, Western Division. Venue is proper in this Court against these defendants pursuant to 15 U.S.C. § 15 and 28 U.S.C. § 1391(b). Service of process is obtainable upon defendants pursuant to 15 U.S.C. § 22.

Parties

3. Plaintiff NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER ("NATIONAL GERIMEDICAL HOSPITAL") was and is a not-for-profit corporation organized and existing under the laws of the State of Missouri. On or about July 30, 1978, NATIONAL GERIMEDICAL HOSPITAL is scheduled to open and operate a 120-bed general acute care hospital licensed by the State of Missouri specializing primarily in geriatric medicine at the address set forth in the caption hereto. From and after July 30, 1978, NATIONAL GERIMEDICAL HOSPITAL will be a provider of hospital services.

4. Defendant BLUE CROSS OF KANSAS CITY ("BLUE CROSS") was and is a corporation organized and existing under the laws of the State of Missouri having and maintaining its principal place of business at the address set forth in the caption hereto. BLUE CROSS offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas and contracts with hospitals and other health service providers for administration of its health care reimbursement plans.

5. Defendant BLUE CROSS ASSOCIATION ("BCA") was and now is a corporation organized and existing under the laws of the State of Illinois and having its principal place of business at the address set forth in the caption hereto. BCA is a national organization offering private health care reimbursement plans and programs to national subscribers and national subscriber groups in numerous states, including Missouri and Kansas. BCA coordinates Blue Cross national policies and programs offered by local and regional Blue Cross Plans, including defendant BLUE CROSS.

Non-Party Co-Conspirators

6. MID-AMERICA HEALTH SYSTEMS, INC., ("MAHSA") was and now is a not-for-profit corporation organized and existing under the laws of the State of Missouri having its principal place of business at 20 West Ninth Street, Kansas City, Missouri 64105. MAHSA is named herein as a co-conspirator with defendants but not as a defendant at this time. MAHSA is a non-governmental organization engaged in the voluntary evaluation of health care services in its designated service area, including numerous counties in Missouri and Kansas.

7. Gary L. Ihde is Vice President, Institutional Provider Affairs, of BLUE CROSS. He is also a member of the Board of Directors and Treasurer of MAHSA. Mr. Ihde is named herein as a co-conspirator with defendants but not as a defendant at this time.

8. Elias E. Zirul, D.O., 6724 Troost, Suite 600, Kansas City, Missouri 64113, is a member of the Board of Trustees of BLUE CROSS and also is a member of the Board of Directors of MAHSA. Dr. Zirul is named herein as a co-conspirator with defendants but not as a defendant at this time.

9. Charles L. Aylward is a member of the Board of Trustees of BLUE CROSS representing the interests of the public and is named herein as a co-conspirator with defendants but not as a defendant at this time.

10. Earl E. Horton, Executive Director, Independence Sanitarium and Hospital, is a member of the Board of Trustees of BLUE CROSS representing the interests of area hospitals, and is named herein as a co-conspirator with defendants but not as a defendant at this time.

11. Independence Sanitarium and Hospital, 1509 West Truman Road, Independence, Missouri 64050, is a Blue Cross Participating Hospital under contract with BLUE CROSS and is named herein as a co-conspirator with defendants representing all Blue Cross Member Hospitals having contracts with BLUE CROSS but not as a defendant at this time.

12. Other individuals, firms or entities now unknown to plaintiff and unnamed are hereby designated as co-conspirators with defendants but not as defendants at this time.

The Nature of Trade and Commerce

13. BLUE CROSS and BCA are major providers of private health care plans in Western Missouri and Eastern Kansas; BLUE CROSS has approximately 800,000 Kansas City area individual plan subscribers. Approximately 40 percent of BLUE CROSS individual plan subscribers participate through national contracts negotiated by BCA and administered locally by BLUE CROSS. A substantial portion of all hospital admissions, in-patient and out-patient treatment

in the BLUE CROSS service area are of BCA or BLUE CROSS individual subscribers. All general acute care hospitals in the BLUE CROSS service area except NATIONAL GERIMEDICAL HOSPITAL are BLUE CROSS Participating Hospitals. BLUE CROSS individual subscribers receive one hundred percent (100%) reimbursement for all covered hospital services at a BLUE CROSS Participating Hospital. Reimbursement by BLUE CROSS is direct to such hospitals. However, BLUE CROSS individual subscribers receive only eighty percent (80%) reimbursement for the same services at a non-participating hospital, and reimbursement for services in a non-participating hospital is direct to the individual BLUE CROSS subscriber, not to the hospital.

14. BCA offers private health care plans to national organizations and groups such as National Federal Employees, United Auto Workers, United States Steel, and Western Electric Employees, throughout the United States, including Missouri and Kansas. Such national contracts are administered and performed through local BLUE CROSS plans. The negotiated terms of such national contracts control the percentage of reimbursement available to individual group members at BLUE CROSS Participating Hospitals and non-participating hospitals.

15. NATIONAL GERIMEDICAL HOSPITAL will specialize primarily in health care services for the elderly. Plaintiff is one of the first such hospitals in the United States. It is intended to serve a national constituency of the elderly through research and development of improved care for the aged. The operation of NATIONAL GERIMEDICAL HOSPITAL will involve and affect interstate commerce in its services to out of state patients, the purchase of drugs and supplies from out of state sources, the receipt of income and reimbursement from out of state insurance companies and the involvement of out of state financing to build and operate the facility.

16. On or about February 16, 1978, NATIONAL GERIMEDICAL HOSPITAL submitted its Amended Application for Blue Cross Participating Membership to BLUE CROSS, seeking a contract with BLUE CROSS as a participating hospital entitled to all the benefits thereof, including one hundred percent (100%) direct reimbursement for service to all BLUE CROSS individual subscribers.

17. On or about March 21, 1978, BLUE CROSS, acting through its Board of Trustees, denied NATIONAL GERIMEDICAL HOSPITAL participating hospital membership status for the sole and exclusive reason that NATIONAL GERIMEDICAL HOSPITAL failed to demonstrate a need for its hospital. In all other respects, the Application of NATIONAL GERIMEDICAL HOSPITAL for membership as a Blue Cross Participating Hospital met and satisfied all requirements of BLUE CROSS.

Offenses Charged

COUNT I

18. Defendants BLUE CROSS and BCA and the co-conspirators named herein, and each of them, have and are engaged in a continuous combination and conspiracy to unreasonably restrain trade in the health care market in the Kansas City, Missouri, Metropolitan Area in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Said conspiracy consists of a continuing combination and agreement, the nature and effect of which is to restrict plaintiff's entry into the health care market and to foreclose to plaintiff an economically significant portion of said market as follows:

(a) On January 1, 1976, BLUE CROSS and BCA established "Prerequisites for Application as a Blue Cross Participating Hospital" requiring *inter alia* evidence that an applicant hospital meets "a clearly evident need for health care services in its defined service area."

BLUE CROSS has designated MAHSA as the agency to conduct "need review" of proposed health care services for BLUE CROSS. It is established BLUE CROSS policy that failure to secure MAHSA approval will result in the denial of any Application to be a BLUE CROSS participating member hospital.

(b) No law requires any provider of health services in Missouri to seek review from nor to secure the approval of MAHSA or any other organization for any health service or hospital expenditure. No law designates or establishes any agency, group or entity in Missouri for such purpose. But for BLUE CROSS and BCA policy requiring establishment of need for proposed health services, MAHSA has no authority nor power to compel health service review nor to impose sanctions to enforce its determinations.

(c) MAHSA, at all times here pertinent, has publicly stated its established policy to prohibit and disapprove any more general acute care hospital beds in its health service area, including the Kansas City, Missouri, Metropolitan Area, and consistently has refused to consider favorably any additional hospital beds in its service area, whether in connection with new hospital facilities or as additions to existing area hospitals. No reasonable possibility of approval by or recommendation of need for NATIONAL GERIMEDICAL HOSPITAL'S 120-bed facility was or is possible through MAHSA. No such review or approval is required by any applicable law.

(d) MAHSA, through its agents and co-conspirators Gary L. Ihde and Elias E. Zirul, has stated that it will not approve plaintiff's hospital nor find any need therefor, notwithstanding plaintiff hospital's emphasis on geriatric medicine and regulations under Public Law 93-641 recognizing a special need for additional health care services and special facilities for the el-

derly. Defendants BLUE CROSS and BCA have advised NATIONAL GERIMEDICAL HOSPITAL that notwithstanding its projected cost effectiveness, BLUE CROSS will not extend Blue Cross Participating Member status to it nor enter into a Blue Cross Participating Contract with plaintiff without the prior approval of MAHSA.

(e) Defendants BLUE CROSS and BCA have combined, contracted and conspired with each other and with co-conspirator MAHSA; with each other and with co-conspirators Gary L. Ihde and Elias E. Zirul, acting in their capacities as an officer and members of the board of MAHSA; and with each other and with co-conspirators Earl E. Horton and Independence Sanitarium and Hospital, acting on behalf of and representing the interests of area hospital competitors of plaintiff, (i) to deny plaintiff hospital Blue Cross Participating Membership thereby foreclosing plaintiff's access to a significant portion of the health care services market, and (ii) to limit, restrict and foreclose plaintiff's entry into the health care services market as a health care provider on an equal basis with competitor area hospitals.

(f) Defendants BLUE CROSS and BCA have combined, contracted and conspired with each other and with all other co-conspirators named herein to interrupt, interfere with, depress or eliminate competition between and among plaintiff and other area hospitals by means of and through the aforementioned combinations and agreements to refuse to deal with and to boycott NATIONAL GERIMEDICAL HOSPITAL and to deny it the privileges and significant economic market advantages of Blue Cross Participating Hospital Membership, all under the guise of controlling and reducing health care costs but to the detriment and injury to plaintiff's business and property and to that of the general public.

COUNT II

19. Paragraphs 1 through 17 hereof are by this reference incorporated into Count II as though fully set forth at this point.

20. Defendants BLUE CROSS and BCA have and are engaged in a continuous combination and conspiracy to boycott plaintiff hospital and to refuse to deal with plaintiff hospital, thereby unlawfully denying plaintiff Blue Cross Participating Hospital Member status to the detriment and injury of plaintiff's business and property notwithstanding plaintiff's compliance with all applicable state and federal laws. Defendants' said unlawful combination and conspiracy to boycott plaintiff and defendants' concerted refusal to deal with plaintiff is a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

COUNT III

21. Paragraphs 1 through 17 hereof are by this reference incorporated into Count III as though fully set forth at this point.

22. Defendants BLUE CROSS and BCA and co-conspirators Charles V. Aylward and others representing the public interest have combined and conspired to engage in a concerted refusal to deal with plaintiff and a continuous combination and conspiracy to boycott plaintiff hospital and to coerce all Blue Cross individual subscribers, members of the general public, to refuse to deal with and to boycott plaintiff hospital by BLUE CROSS' denial of participating hospital membership to plaintiff under the guise of health care cost containment but without justification or excuse in fact or law.

23. Approximately 800,000 BLUE CROSS individual subscribers, members of the general public, are involuntary participants in said unlawful combination and conspiracy in that said individual subscribers are economically coerced

to seek health care at competitor Blue Cross Member Hospitals and not at plaintiff hospital.

24. Each and every act, combination and conspiracy to boycott, to refuse to deal and to coerce others to boycott and to refuse to deal as alleged in Count III hereof is a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1.

COUNT IV

25. Paragraphs 1 through 17 hereof are by this reference incorporated into Count IV as though fully set forth at this point.

26. The acts and conduct of defendant BLUE CROSS as alleged and set forth in Counts I, II and III hereof, constitute an unlawful abuse of its monopoly power in the private health care reimbursement plan market for the purpose of and in an unlawful effort to extend and expand its said power into the health care services market and the health care provider market in order to control market entry by health service providers and to dictate the terms of access to the health care services market and to prevent free and open competition among health care service providers, all under the guise of health care cost containment but to the detriment of plaintiff's business and property and to the detriment of the general public.

27. The acts and conduct alleged and set forth in Count IV hereof are a violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

COUNT V

28. Paragraphs 1 through 18 hereof are by this reference incorporated into Count V as though fully set forth at this point.

29. Defendants' said agreements, combinations and conspiracies constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VI

30. Paragraphs 1 through 17 and paragraph 20 hereof are by this reference incorporated into Count VI as though fully set forth at this point.

31. Defendants' said agreements, combinations and conspiracies to boycott and refuse to deal with plaintiff constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VII

32. Paragraphs 1 through 17 and paragraphs 22 through 24 hereof are by this reference incorporated into Count VII as though fully set forth at this point.

33. Defendants' agreements, combinations and conspiracies to coerce others to boycott and refuse to deal with plaintiff constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-1, RSMo. (1975 Supp.).

COUNT VIII

34. Paragraphs 1 through 17 and paragraphs 26 through 27 hereof are by this reference incorporated into Count VIII as though fully set forth at this point.

35. Said acts of defendant BLUE CROSS constitute unlawful restraints of trade or commerce in the State of Missouri in violation of Section 416.031-2, RSMo. (1975 Supp.).

Injury to Plaintiff

36. By reason and as a direct and proximate result of the unlawful acts and conduct of defendants and others set forth in paragraphs 18 through 35 hereof, plaintiff NATIONAL GERIMEDICAL HOSPITAL has been and is injured in its business and property in that:

(a) Potential patients of plaintiff hospital will be unwilling to and will refuse to deal with or patronize plaintiff's hospital and to utilize the health care services offered by plaintiff;

(b) Plaintiff will be unable to attract BLUE CROSS individual subscribers who are coerced and forced to seek medical services elsewhere in order to utilize the full benefits of their BLUE CROSS subscriber contracts;

(c) By reason of substantially reduced patient access and patronage, plaintiff will be unable to attract and to maintain a high quality, full service medical staff and will be unable to maintain low cost quality health care services;

(d) Plaintiff's good will and public faith have been and will continue to be destroyed and undermined due to BLUE CROSS' combination and conspiracy to restrict entry into the health care service market and to refuse participating member hospital status to plaintiff, which unlawful actions have called into public scrutiny and doubt the propriety, efficiency and cost effectiveness of plaintiff's hospital, all without basis in fact;

(e) The value of plaintiff's hospital buildings and facility and the value of plaintiff's hospital operation has been substantially diminished and impaired;

(f) Plaintiff's ability to obtain and retain commitments for both interim and long term financing and for public financial support and for the support of foundation contributors on which plaintiff relied is substantially impaired and destroyed;

(g) Plaintiff's ability to provide low cost, effective, quality health care services to the general public and particularly the elderly has been substantially impaired and irrevocably damaged and plaintiff is and

will continue to incur disproportionate expenses and costs of operation all of which could be avoided in a free, open and competitive health care market.

Damages

37. Plaintiff does not know and has not at this time determined the full extent of its damages, but believes that plaintiff's actual damages from all causes herein alleged will exceed One Million Six Hundred Thousand and No/ Dollars ($1,600,000.00). When plaintiff has ascertained the extent of its damages, plaintiff will seek leave to amend its Complaint and allege its damages.

Prayer for Relief

WHEREFORE, plaintiff NATIONAL GERIMEDICAL HOSPITAL prays:

(a) That defendants BLUE CROSS and BCA, and each of them, be adjudged and determined to have violated the antitrust laws of the United States of America and of Missouri as herein set forth and alleged;

(b) That Plaintiff NATIONAL GERIMEDICAL HOSPITAL have judgment against BLUE CROSS and BCA, and each of them, for three times the total amount of its actual damages incurred and its reasonable attorney's fees herein incurred and expended as required by law;

(d) That defendants, and each of them, be enjoined from further violation in each and every respect hereinbefore alleged of the antitrust laws; and

(e) That plaintiff have and recover such other and further relief as the Court may deem proper.

Plaintiff hereby demands trial by jury.

JOHNSON, LUCAS, BUSH & SNAPP

KENT SNAPP
JAMES M. BECK
1414 Home Savings Building
1006 Grand Avenue
Kansas City, Missouri 64106
(816) 471-1157

Attorneys for Plaintiff
National Gerimedical Hospital
and Gerontology Center

DEFENDANT BLUE CROSS ASSOCIATION'S MOTION TO DISMISS OR, ALTERNATIVELY, MOTION TO STAY

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

Comes now the defendant Blue Cross Association ("BCA"), pursuant to Rule 12(b), Fed.R.Civ.P., and moves to dismiss plaintiff's Complaint on the following grounds:

1. The Complaint fails to state a claim upon which relief can be granted because the McCarron-Ferguson Act exempts the challenged activity from the antitrust laws;

2. This Court lacks jurisdiction over the subject matter of the Complaint because the challenged activity does not affect interstate commerce;

3. All pendent claims arising under Missouri law should be dismissed because of the plaintiff's failure to state a claim for relief based upon federal law and because of the court's lack of jurisdiction over the federal claims; and

4. Even assuming *arguendo* that the above 3 grounds for dismissal did not exist, the Complaint must be dismissed as to BCA because the allegations made are insufficient to support plaintiff's theory of BCA's conspiracy with defendant Blue Cross of Kansas City.

Alternatively, for the reasons set forth in BCA's Suggestions, Part IA, pp. 11 and 12, fn. 4, if this action is not dismissed, it should at least be stayed pending the United States Supreme Court's decision in *Royal Drug Co.* v. *Group Life & Health Insurance Co.*, 556 F.2d 1375 (5th Cir. 1977), *cert. granted*, 98 S. Ct. 1448 (1978).

Pursuant to Local Rule 10 of this court, suggestions in support of this motion have been served on counsel of record and are filed herewith.

STINSON, MAG, THOMSON, MCEVERS & FIZZELL

By /s/ JOHN C. NOONAN by REH
John C. Noonan

By /s/ RANDALL E. HENDRICKS
Randall E. Hendricks
P. O. Box 19251
Kansas City, Missouri 64141
(816) 842-8600

Attorneys for Defendant
Blue Cross Association

(Certificate of Service omitted in printing.)

MOTION OF DEFENDANT BLUE CROSS OF KANSAS CITY TO DISMISS PLAINTIFF'S COMPLAINT

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

Defendant Blue Cross of Kansas City (hereinafter Blue Cross) moves the Court for its Order dismissing plaintiff's Complaint and all Counts thereof on the following grounds:

1. The Complaint fails to state a claim upon which relief can be granted as to this defendant.

2. The Complaint fails to state a claim upon which relief can be granted because all claims against this defendant, alleged in the Complaint, are exempted from the antitrust laws of the United States by the McCarran-Ferguson Act; this defendant is in the business of insurance and is subject to the regulation by the states of Missouri and Kansas, within the meaning of the McCarran-Ferguson Act, 15 U.S.C. 1011, *et seq.*, so that this Court lacks jurisdiction over the subject matter of this action within the meaning of F. R. Civ. P. 12(1).

3. No pendent jurisdiction exists for claims arising under Missouri law so that Counts V through VIII of plaintiff's Complaint should be dismissed as they fail to state a claim upon which relief can be granted based on Federal Law and because of the Court's lack of jurisdiction over Counts I through IV.

4. This Court lacks jurisdiction over the subject matter of this case because the claims against this defendant, based upon the sale of prepaid health insurance plans by not-for-profit corporations, is not trade nor commerce within the meaning of the Sherman Act, 15 U.S.C. 1 and 2.

5. Plaintiff's Complaint, as a matter of law, does not allege any illegal conspiracy or concerted activity within the meaning of the Sherman Act by this defendant or any other person or party.

6. Plaintiff's Complaint, and particularly Counts I through IV, fail to state a claim for relief against this defendant because plaintiff's Complaint alleges conduct of this defendant which was within the intent, directive and mandate of the National Health Care Planning Act, 42 U.S.C. 300k *et seq* and thus, not subject to the antitrust laws.

7. Defendant Blue Cross attaches and makes a part hereof, the Affidavit of Jerry B. Buxton as Exhibit A; the Affidavit of Fletcher Bell as Exhibit B and incorporates by reference the Affidavit of Donald L. Flora and the copy of the 1978-1982 Health Systems Plan of Mid-America Health Systems Agency attached to the Flora Affidavit as Exhibit A, both filed separately this date in this action because of the bulk of the Health Systems Plan.

WHEREFORE, defendant Blue Cross of Kansas prays the Order and Judgment of this Court dismissing plaintiff's Petition and for this defendant's costs herein incurred.

Respectfully submitted,

/s/ HARRY P. THOMSON, JR.
Harry P. Thomson, Jr.

/s/ GEORGE E. LEONARD
George E. Leonard

and

/s/ DENNIS D. PALMER
Dennis D. Palmer

of

SHUGHART, THOMSON & KILROY,
A Professional Corporation
Ninth Floor Commerce Bank Bldg.
P. O. Box 13007
Kansas City, Missouri 64199
816/421-3355

and

/s/ MAX O. BAGBY by Apt
Max O. Bagby

of

BAGBY, BENJAMIN & ARNOLD
2320 Commerce Towers
Kansas City, Missouri 64199

Counsel for Blue Cross of Kansas City

(Certificate of Service omitted in printing.)

Attachment to the Suggestions of Blue Cross Association in Support of Motion to Dismiss.

AFFIDAVIT OF DONALD L. FLORA

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

(Title omitted in printing)

I, Donald L. Flora, being first duly sworn on oath depose and say:

1. I am a resident of the State of Missouri and reside at 1101 Arno, Kansas City, Missouri. My business office is at 20 West 9th Street, Suite 715, Kansas City, Missouri.

2. I am the Executive Director of Mid-America Health Systems Agency and have personal knowledge of the matters referred to herein.

3. Mid-America Health Systems Agency is fully designated by the United States Department of Health, Education and Welfare as the health planning body for the eight-county, bi-state, Kansas City metropolitan area including the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and the counties of Johnson, Leavenworth and Wyandotte in Kansas (hereinafter referred to as "the health systems area").

4. Exhibit A, attached hereto, is a true and correct copy of the 1978-1982 Health Systems Plan for the health systems area.

5. The 1978-1982 Health Systems Plan, identified in paragraph 4 as Exhibit A, was prepared by the Mid-America Health Systems Agency pursuant to and in accordance with Section 1513(b)(2) of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 3001-2(b)(2).

/s/ DONALD L. FLORA
Donald L. Flora

PREVIOUS PAGE WAS BLANK

Subscribed and sworn to me by the said Donald L. Flora this 12th day of July, 1978.

/s/ INA K. PEARSON
Notary Public in and for
the State of Missouri

Ina K. Pearson, Notary Public

My Commission Expires April 10, 1981

[NOTARIAL SEAL]

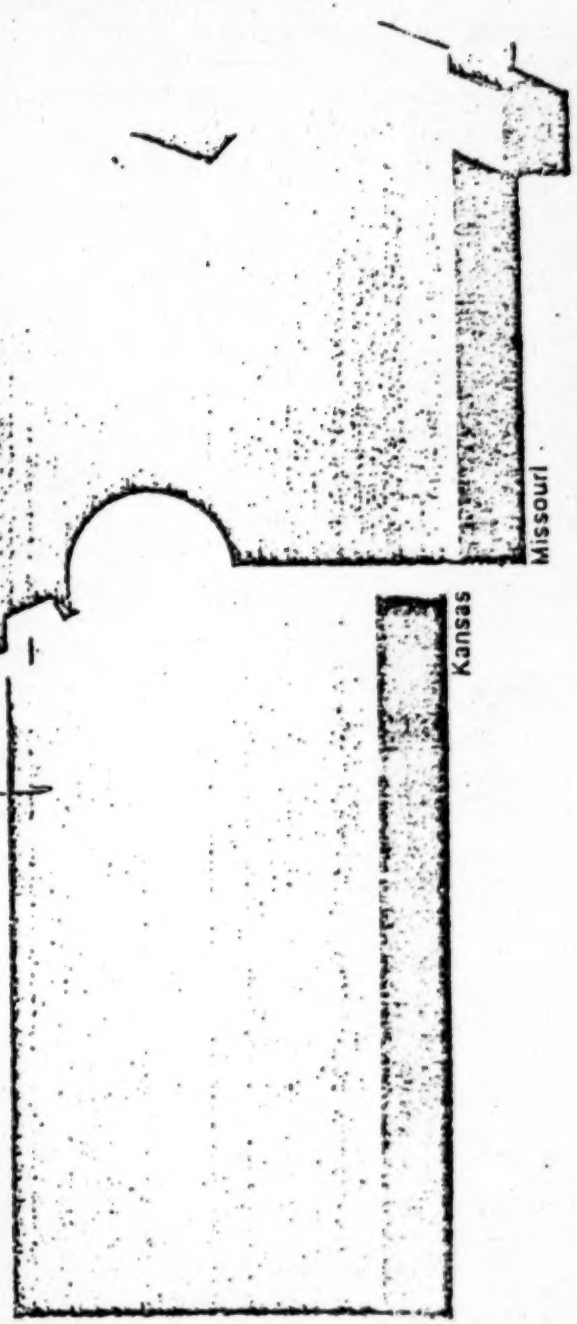
Excerpts from Exhibit A to the Affidavit of Donald L. Flora

EXCERPTS FROM HEALTH SYSTEMS PLAN 1978-1982

(Filed in the United States District Court for the Western District of Missouri, July 14, 1978)

Health Systems Plan

1978-1982



Mid-America Health Systems Agency
20 W. 9th Suite 715
Kansas City MO 64105

FOREWORD

The Mid-America Health Systems Agency was conditionally designated the health planning body for the eight-county, bi-state, Kansas City metropolitan area April 12, 1976. It is one of 205 regional health systems agencies created under Public Law 93-641, the National Health Planning and Resources Development Act of 1974.

One of the primary responsibilities of each of these health systems agencies is the development of a long-range Health Systems Plan (HSP) for the region. The HSP describes how the region's health care delivery system should be changed by the end of 1982 to make it more accessible, available and efficient.

MAHSA's 30-person volunteer Board directed July 30, 1977, that the first six chapters of the Agency's proposed HSP be submitted to the public for comments and suggested modifications.

The Board reviewed the complete HSP and suggested modifications based on these public comments November 12, 1977, and voted November 22 to establish the final HSP, as modified, as the five-year health plan for the region.

The following is the established 1978-1982 Health Systems Plan for the MAHSA region.

TABLE OF CONTENTS

MID-AMERICA HEALTH SYSTEMS AGENCY
HEALTH SYSTEMS PLAN

		Page
Chapter 1.000	INTRODUCTION	1-1
Chapter 2.000	NATIONAL PRIORITIES AND STATEWIDE NEEDS AND PRIORITIES	2-1
Chapter 3.000	GENERAL DESCRIPTION OF THE HEALTH SERVICE AREA	3-1
Chapter 4.000	HEALTH STATUS	4-1
Chapter 5.000	HEALTH SYSTEM	
	Introduction	5-1
	Consumer Health Education	5-7
	Maternal and Child Care	5-23
	Acute Inpatient Care Services	5-53
	Diagnostic Radiology	5-75
	Emergency Medical Services	5-91
	Mental Health Services	5-95
	Rehabilitation Services	5-111
	Long-Term Care	5-117
Chapter 6.000	LONG-RANGE RECOMMENDED GOALS, OBJECTIVES, ACTIONS AND INTERVENTION STRATEGIES FOR SELECTED PROBLEMS	
	Introduction	6-1
	Health Status	6-3
	Consumer Health Education	6-9

		Page
	Maternal and Child Care	6-13
	Acute Inpatient Care Services	6-19
	Diagnostic Radiology	6-25
	Mental Health Services	6-33
	Rehabilitation Services	6-37
	Long-Term Care	6-39
Chapter 7.000	Summary	7-1
Chapter 8.000	Priorities for Annual Implementation Plan	8-1
Chapter 9.000	Areas for Future Consideration	9-1
Chapter 10.000	Evaluation	10-1
Appendices	Demographic Data	Appendix A
	Health Status Data	Appendix B
	Health Systems Service Categories	Appendix C
	Health Care Cost References	Appendix D
	Maternal and Child Care Data	Appendix E
	Acute Inpatient Care Services Data	Appendix F
	Emergency Medical Services Data	Appendix G
	Mental Health Services Data	Appendix H
	Long-Term Care Data	Appendix I
	MAHSA History	Appendix J
	Glossary	Appendix K
Index		

1.000 INTRODUCTION

This introductory chapter is presented to assist the reader in understanding the purpose and use of the Mid-America Health Systems Agency's Health Systems Plan (HSP). The chapter is organized into four sections:

(1) Section *1.100, Statutory Authority,* provides an explanation of the legal basis which gives the Mid-America Health Systems Agency its authority to function.

(2) Section *1.200, The Mid-America Health Systems Agency,* summarizes the Agency's development and presents the Agency's planning policies and responsibilities.

(3) Section *1.300, Purpose and Use of the Health Systems Plan,* outlines the purpose and organization of the HSP.

(4) Section *1.400, The Process for Evaluating the Planning Effort,* expresses the Agency's intent to provide community involvement in evaluating its planning activities.

1.100 Statutory Authority

1.110 *Federal Authority*

Public Law 93-641, the *National Health Planning and Resources Development Act of 1974,* was signed into law by President Gerald R. Ford January 4, 1975. PL 93-641 amended the Public Health Service Act ". . . to assure the development of a national health policy and of effective State and area health planning and resources development programs. . ."[1]

In amending the Public Health Service Act, Congress intended to facilitate the development of recommendations

---

[1] PL 93-641, 93rd Congress, S.2994, January 4, 1975, page 1.

for a national health planning policy, to authorize financial assistance for the development of resources to further that policy, and to augment areawide and state planning for health services, manpower, and facilities.

By adding two new titles to the Public Health Service Act (Title XV—*National Health Planning and Development* and Title XVI—*Health Resources Development*), Congress created a network of national, state and local health planning groups (Title XV) and a mechanism (Title XVI) to provide assistance through allotments, loans, loan guarantees and interest subsidies to medical facilities needing to modernize, construct new inpatient facilities or convert to a new form of health services.

The health planning network created under Title XV consists of four groups—one at the national level, two at the state level, and one at the local level. Each group has separate, but related and coordinated functions.

At the national level there is an advisory body known as the National Council on Health Planning and Development which advises, consults with and makes recommendations to the Secretary of Health, Education and Welfare concerning the development of national guidelines on national health planning policy, and the development and implementation of Titles XV and XVI. The Council also is charged with evaluating the implications of new medical technology for the organization, delivery and equitable distribution of health care services.

At the state level, the two groups are the Statewide Health Coordinating Council (SHCC) and the State Health Planning and Development Agency (the SHPDA or State Agency).

The major functions of the Statewide Health Coordinating Council are to prepare, review, and revise at least annually a state health plan. Based upon the state health plan, the SHCC must review annually and approve or dis-

approve any state plan and any application to be submitted to the Department of Health, Education and Welfare for funds or allotments made to the state under the Public Health Service Act, the Community Mental Health Centers Act, or the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

The State Health Planning and Development Agency (SHPDA) has many functions—the primary one being to conduct the state's health planning and development activities. The SHPDA is an agency of the state government; the SHCC is an advisory group consisting of unpaid volunteers appointed by the governor of each state.

The fourth group, which completes the network for health planning, is a local entity called a Health Systems Agency (HSA). Each health systems agency is in charge of all health planning activities in a limited geographic area called a health service area. The work of each health systems agency is guided by a governing body (unpaid volunteers) and performed by a professional planning staff.

Each HSA is responsible for:

(1) improving the health of residents of its health service area;

(2) increasing the accessibility (including overcoming geographic, architectural and transportation barriers), acceptability, continuity and quality of the health services provided;

(3) restraining increases in the cost of providing area residents health services; and

(4) preventing unnecessary duplication of health resources.

To accomplish these purposes, each HSA has as its primary responsibility the provision of effective health planning for its health service area and the promotion of

the development within the area of health services, manpower and facilities which meet identified needs, reduce documented inefficiencies and implement its health plans. The document which records the results of the planning efforts of each HSA is the Health Systems Plan.

The Health Systems Plan is a detailed statement of goals describing a healthful environment and health system for the area, which when developed, will assure that quality health services are available and accessible in a manner which assures continuity of care at a reasonable cost for all residents of the area and which is responsive to the unique needs and resources of the area.

1.120 *Kansas Authority*

The *Kansas Health Planning and Development Act*, K.S.A. 65-4701, signed by Governor Robert Bennett on April 14, 1976, authorized the establishment of a Statewide Health Coordinating Council, a State Health Planning and Development Agency in the Department of Health and Environment, and four health systems agencies within the state.

1.130 *Missouri Authority*

Missouri has not enacted specific legislation implementing PL 93-641. By administrative authority, a Statewide Health Coordinating Council and a State Health Planning and Development Agency within the Department of Social Services have been established. There are five health systems agencies in the state.

1.140 *Mid-America Health Systems Agency, Inc., By-Laws*

The Mid-America Health Systems Agency, Inc., is a private not-for-profit corporation chartered November 12, 1975, under the laws of the State of Missouri and authorized to do business in Kansas as a foreign corporation.

The Agency, with corporate offices in Missouri, is organized for the sole purpose of providing health planning for its health service area and is operated in a manner consistent with the purpose, requirements, specifications, duties and functions of a health systems agency as defined in Title XV of PL 93-641, subsequent amendments and corresponding provisions of any subsequent federal health planning legislation and related regulations and guidelines.

The Agency serves the Kansas City metropolitan area (designated Kansas Health Service Area #4—Johnson, Leavenworth and Wyandotte Counties; and Missouri Health Service Area #1—Platte, Clay, Ray, Jackson and Cass Counties).

1.200 Mid-America Health Systems Agency

1.210 *Agency History*

This section is designed to record MAHSA's history—how it was initially organized and established. The historical perspective was presented and well documented in the Agency's initial application and subsequent court case.

MAHSA's development was an open process characterized by citizen involvement and participation. MAHSA was formed by a group of dedicated citizens committed to the establishment of a freestanding, not-for-profit health planning agency that would be open to participation by the entire community and which would not be controlled by any one group. MAHSA has maintained continuous public participation in its development and has benefited greatly from this involvement. (For a detailed chronology of MAHSA's history, see Appendix J.)

1.220 *Agency Policies*

On March 24, 1977, MAHSA's Board of Directors adopted six major policies designed to provide the philosophical basis for the development of any and all health systems plans promulgated or sponsored by the Agency.

These policies define for the community what health planning responsibilities the Agency has, the commitments it tenders to the area's health care consumers and providers, and the Agency's intent to communicate and inform individuals and organizations not directly associated with it.

The six planning policies—and the reasons and implications for each—are presented below. The six policies must be viewed in their totality. Collectively they provide the parameters of the Agency's planning efforts. Individually each policy presents the Agency's statement of its responsibilities to one or more elements of the Kansas City metropolitan area.

The Mid-America Health Systems Agency:

(1) Considers Its Responsibility in Health Planning to Include the Health of the Area Residents, the Human, Environmental and Social Factors That Influence Health, and the Preventive, Curative and Restorative Health Services That Impact on the Maintenance and Improvement of the Health of the Area's Residents.

This policy defines the eventual scope of health planning. It recognizes that the health of the area residents is impacted by the total society. A policy which defines health planning in this manner allows and encourages exploring health care problems without being artificially limited. It also permits exploring solutions to these problems which may lie outside of the medical world but may have as much or more relevancy and positive impact on the problem than a medical solution. This policy does not require that the full scope of health planning ever be explored. The policy does, however, permit such exploration if priorities and resources so indicate.

(2) Will Base Health Planning on the General and Specific Needs of All Area Residents.

This policy commits the Agency to population-based planning as opposed to resource or facilities oriented planning. The policy is established so that no program can or should ever be justified on any basis other than the contribution that program or service will make to the health of the area's residents. If a resource is to be allocated to this metropolitan area, the need for that resource must be found or identified in the population, not within the sponsorship of the program.

This policy also mandates that, whenever possible, the needs of specific population sub-groups will be identified, addressed and considered.

(3) Will Develop Goals, Objectives and Activities Directed Toward an Area Health Service System Providing Quality Services That Are Available, Accessible and Acceptable to Area Residents and That Provide Continuity of Care and Contain or Reduce Costs Wherever Possible.

Policy 3 commits the Agency to developing a health delivery system that assures the most appropriate quality health services. It also mandates that a variety of criteria be utilized in developing the health service system. The policy recognizes that the provision of high quality services involves a realization that the judgment of quality contains factors which are found in an individual's value system. The system developed will represent value judgments which reflect the community value system rather than technical definitions of quality.

(4) Will Take Positions Promoting Changes in the Existing Health Care Delivery System Only When the Change Will Result in Needed Improvement in Qual-

ITY OF CARE, AVAILABILITY OF SERVICES, ACCESSIBILITY OF SERVICES, ACCEPTABILITY OF SERVICES, CONTINUITY OF CARE OR COST OF SERVICES.

Policy 4 is the Agency's commitment to the area's health care providers to make every attempt to work with the existing delivery system in order to build on the experience, strengths and organized resources in that system while striving to correct any weaknesses.

(5) CONSIDERS THAT QUALITY OF LIFE IS OF PRIMARY IMPORTANCE IN EVALUATING THE EFFECTS OF HEALTH SERVICES AND WILL TAKE QUALITY OF LIFE EFFECTS INTO CONSIDERATION IN ALL PLANS AND DECISIONS.

This policy recognizes the duality and continuous conflict of the present health care system. At the same time that the delivery system is trying to delay death, i.e., increase an individual's life span, the system attempts to do something about the individual's ability to function within that life span. An attempt to emphasize both directions suggests unlimited resources available to health care. Policy 5 recognizes that there are severe limits on resources in general and specifically those available for use by the health care system. Policy 5 presents this community's choice as to the health care system's emphasis. The policy directs that the purpose of the Kansas City area's health care delivery system be to assist area residents in achieving an individually acceptable quality of life. This policy mandates less emphasis on reactive medicine and more emphasis on preventive measures and practical public education on health matters. This policy permits emphasis on restorative measures but mandates that programs be designed to eliminate the need for restorative or recuperative services.

Policy 5 very carefully avoids defining the term "quality of life." Quality of life is a subjective matter best

left to each individual's choice. To some, quality of life means good health; to others it means a certain physical status; to still others, quality of life is defined by the individual's ability to perform certain functions.

Policy 5 requires that the Agency plan a health care delivery system which helps an individual maximize the quality of life.

(6) WILL MAKE AVAILABLE TO THE PUBLIC ALL BACKGROUND DATA, ANALYSES AND UNDERSTANDABLE STATEMENTS OF THE REASONS FOR ANY GOALS, OBJECTIVES, RECOMMENDED ACTIONS OR DECISIONS OF THE AGENCY.

The Agency recognizes a need to keep area residents informed in a meaningful way of its actions. Policy 6 presents the Agency's intention to maintain an open, public approach to planning and of communicating its actions to the community in an understandable manner.

1.230 *Agency Responsibilities*

PL 93-641 defines the Agency's legal responsibilities and purposes (Section 1.110). There is, however, another area of responsibility which is not specifically mandated by the law but is inherent in this Agency's functioning. Whatever Health Systems Plan is finally developed, two obligations must be fulfilled.

The first obligation involves the community's right to define and implement a health delivery system which accurately reflects its value system and meets its needs. The Agency has the obligation and responsibility to outline for the community alternatives and consequences of those alternatives. The Agency understands its obligation to devise a Health Systems Plan which is satisfactory to the community, while accepting the responsibility of a leadership position in helping the community make careful, thoughtful choices in the selection of a health care system.

The second obligation involves the Agency's need to be realistic in terms of what it can accomplish alone. The Agency has to assume responsibility for helping the community see and anticipate future needs and directions. The Agency realizes that without the assistance, involvement and willing participation of consumers, providers, elected officials and other community leaders, no Health Systems Plan, no matter the quality, will be implemented. The Agency has assumed a responsibility to involve the greatest number of people possible in its planning process. It is hoped that the process utilized has led to a realistic statement about the Kansas City area's health care system.

1.300 Purpose and Use of the Health Systems Plan

This section is designed to help the reader use and understand the Health Systems Plan.

1.310 *Purpose*

The purpose of the Health Systems Plan is to define a health care delivery system for the eight-county Kansas City metropolitan area which, in the year ending December 31, 1982, will improve the area residents' quality of life.

The Health Systems Plan will provide a continuing series of high level policy statements which can and should be used as a guide for resource allocation by community leaders.

Like all segments of society, the health care system has operated on the assumption that resources in general, and health care resources in particular, are unlimited. Due to the perception of unlimited resources, the health care system has tried to do a tremendous number of things without having a clear focus in mind or being cognizant of the need to consider tradeoffs in decision making.

The Health Systems Plan reflects the community's statement of the health system's goal: improvement in the qual-

ity of life. The Health Systems Plan then will suggest how important it is to the community that the health care system accomplish its goal and what resources are to be available. It then will indicate how the resources available to the health care system should be allocated in order to accomplish an improved quality of life.

MAHSA's Health Systems Plan will present a statement that defines the role and scope of the Kansas City area's health care delivery system and a recommendation as to where the system fits into the other social and economic systems which define and describe the society in which area residents function.

1.320 ***Use of the Health Systems Plan***

Using the Health Systems Plan becomes in many ways the most difficult part of the planning process. Two items need to be discussed. The first deals with the physical organization of the Plan; the other deals with implementing the Plan.

1.321

When reading the Health Systems Plan, Chapters 1.000, 2.000 and 3.000 can be considered as one unit.

Chapter 1.000 is introductory. Chapter 2.000 presents problems which someone or some organization has indicated should be examined. No attempt is made in Chapter 2.000 to judge whether or not these problems exist. The problem statements are presented only as hypotheses to be tested. They are presented as starting points with no further justification than the fact that someone has indicated a problem may exist. The Agency's investigation may not be limited to those items expressed in Chapter 2.000. Chapter 3.000 presents a display of the area's socio-economic statistics along with national and regional statistics. Statements will be made explaining the use of certain statistics

in health planning. Conclusions will be drawn in this Chapter related to the health status of the population.

Chapters 4.000, 5.000 and 6.000 are the heart and core of the Health Systems Plan. Chapters 4.000 and 5.000 are analytical in nature. These chapters analyze problems from Chapter 2.000 and data presented in Chapter 3.000. In succeeding plans, and as the state of the art develops, every problem presented in Chapter 4.000 will lead to some component in Chapter 5.000. The reverse is not necessarily true.

Chapter 6.000 presents goal statements based on the analyses done in Chapters 4.000 and 5.000. If Chapters 4.000 and 5.000 are considered analytical and final definitions of problems, Chapter 6.000 presents the results of that analysis in terms of goals, objectives and action plans.

Chapter 7.000 is an overall summary with a reconciliation between Chapters 2.000 and 6.000. Chapter 8.000 provides the basis of the Annual Implementation Plan. Chapter 9.000 outlines areas for future consideration, and Chapter 10.000 eventually will be used to evaluate the effectiveness of the Health Systems Plan.

1.322 *Utilizing the Health Systems Plan*

The Health Systems Plan is designed to present and then assist in the development of the metropolitan area's 1983 health delivery system. The formulation, definition and presentation of the proposed health care system is found in Chapters 4.000, 5.000 and 6.000.

The HSP can and should be used to INFLUENCE the development of the desired system.

The HSP, and consequently the Agency, will have *direct* influence over the allocation and expenditure of federal dollars in certain categorical areas. This influence will be exercised through the Agency's authority to review and approve or disapprove federal grant funds.

MAHSA, using the HSP as a basis, can influence the type, nature and scope of services sponsored by the area's health care institutions through the Agency's procedures for the review of new institutional services. Certificate of Need procedures, utilizing the Health Systems Plan, can also be used to influence the emphasis licensed health care institutions place on certain services.

There are two other ways in which the Health Systems Plan can be used to influence the development of the health care system. Although both ways are far more indirect than the Agency's quasi-regulatory powers, they are probably the most beneficial and productive. The Plan should be used by community leaders as a decision making tool for the allocation of local public and private health care resources. As community leaders—elected officials, corporate decision makers and leaders in the world of medicine—work on their respective priorities and budgets, the Agency's Health Systems Plan can provide guidance and expertise as to the final order of those priorities and the shape of those budgets.

The last area for influence can be found in the public arena. Users of the health care system have a right to know what demands they can make on it and the obligation to make only *appropriate* demands. The Health Systems Plan can be used to help the consumer achieve realistic expectations of the health care system and to utilize it appropriately.

1.400 The Process for Evaluating the Planning Effort

PL 93-641 requires that the end product of the planning process be evaluated by the community, the local and state A-95 clearing house, the Statewide Health Coordinating Council and the State Health Planning and Development Agency. Chapter 10.000—Evaluation of Interventions—will provide a mechanism and process for evaluating the effectiveness of the Plan and accompanying implementation

strategies. The basic approach in Chapter 10.000 will be to utilize the goals and objectives outlined in Chapter 6.000 as a baseline for measuring progress. Subsequent HSPs will reflect the results of the evaluation process outlined in Chapter 10.000.

The community and the Agency have an obligation also to evaluate the planning effort or process itself. Since this document is the Mid-America Health Systems Agency's initial Health Systems Plan, it is not logical at this point to critique and evaluate the process utilized in MAHSA's first 20 months of existence. The Agency will, during the first quarter of 1978, convene residents of the health service area who are familiar with the Agency's operations, whether or not they have actually participated in any phase of the Agency's planning efforts. The purpose of that evaluation will be to identify the strengths and weaknesses of the planning process with the commitment to maintain and build upon the positive aspects and eliminate the negative portions.

2.000 NATIONAL PRIORITIES AND STATEWIDE NEEDS AND PRIORITIES

This chapter presents the national priorities and statewide needs and priorities. These priorities are combined with health priorities of area residents, as expressed by both consumers and public officials, to form a set of health concerns. The health concerns, derived from federal, state and local concerns, will be examined in the subsequent chapters of the HSP.

Health planning priorities for MAHSA's health service area were derived by the process described in Chapter 1.000 and are presented in Chapter 8.000. The concerns listed in this chapter are the initial input into—not the results of—the planning and priority setting process.

2.100 National Guidelines and Priorities

2.110 *National Guidelines for Health Planning*

National guidelines for health planning under PL 93-641 have been issued.[1] The guidelines concerning the development of Health Systems Plans (HSPs) and Annual Implementation Plans (AIPs) were used in the design and preparation of MAHSA's Health Systems Plan.[2] Included in the guidelines are national health planning goals. These goals were not officially adopted in time to be included in the planning process for this year. The goals provided by the guidelines apply generally to the health status and health systems of the nation and may not be relevant to the needs and priorities of every health service area. National goals may not have corresponding goals at the local level in all cases, but no local goals are in conflict with the draft national goals.

2.120 *National Health Priorities*

National health priorities were established as a part of the National Health Planning and Resources Development Act. PL 93-641 requires consideration of these priorities in the formulation of national health planning goals and in the development and operation of federal, state, and area health planning and resources development programs. The following list of priorities is taken directly from PL 93-641, Section 1502:

(a) The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.

---

[1] National Health Planning and Development Act, Part A, Section 1501.

[2] Guidelines Concerning the Development of Health Systems Plans and Annual Implementation Plans, Department of Health, Education, and Welfare, November 1976.

(b) The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services).

(c) The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.

(d) The training and increased utilization of physician assistants, especially nurse clinicians.

(e) The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.

(f) The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under Part B of Title XI of the Social Security Act.

(g) The development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

(h) The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

(i) The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions.

(j) The development of effective methods of educating the general public concerning proper personal (including

preventive) health care and methods for effective use of available health services.

2.130 *Local Relevance of National Priorities*

All of the national priorities have been considered in the development of this Plan. The specific manner in which each priority problem has been considered is described in Section 2.400, Utilization of National and State Priorities.

2.200 Kansas Needs and Priorities

2.210 *Kansas Priority Health Problems*

The following problems have been presented by the Kansas Department of Health and Environment as the 1976-77 priority problems affecting the health of Kansans:[3,4]

Problem (a)	Medical Care Costs
Goals:	Reduce demand for institutional services.
	Reduce need for institutional services.
	Prevent unnecessary facilities and institutional services.
Problem (b)	Abusive Health Behaviors
Goals:	Educate and encourage people to assume responsibility for avoiding self-imposed risks.

---

[3] *A Balanced Perspective on: The Health of Kansans*, Kansas Department of Health and Environment, Topeka, Kansas, December 1976.

[4] The order is the ranking given by the Kansas State Health Planning and Development Agency. This ranking was not accepted by the Kansas Statewide Health Coordinating Council, but the items were accepted.

	Increase the availability and accessibility of services which support appropriate health behavior.
Problem (c)	Care of the Aged
Goal:	Improve access of the aged population to needed primary care services, particularly in rural areas.
	Improve the availability of alternatives to institutional care for the aged population.
Problem (d)	Stressful Social Environment
Goals:	Improve availability and accessibility of support services for people experiencing stress.
	Conduct additional research on social and environmental factors which may be associated with harmful stress.
Problem (e)	Shortage of Primary Care Services (particularly in rural areas of Kansas)
Goal:	Improve the availability of primary care providers in Kansas with a special emphasis on rural areas.
Problem (f)	Emergency Medical Services
Goals:	Improve accessibility of emergency medical services to the public.
	Improve coordination among the agencies providing emergency medical serices.

2.220 *Local Relevance of Kansas Priorities*

All of the Kansas priorities have been considered in the development of this Plan. The specific manner in which each

priority problem has been considered is described in Section 2.400, Utilization of National and State Priorities.

2.300 Missouri Needs and Priorities

2.310 *Missouri Health Priorities*

The Missouri State Health Planning and Development Agency has not prepared a specific priority health problem list. Missouri does have available, however, an inventory of health related needs and priorities compiled by various state agencies.[5]

2.320 *Local Relevance of Missouri Priorities*

The Missouri inventory of health related needs and priorities has not been formed into a State Health Planning and Development Agency health priority statement, but the report has been considered in the development of various parts of the Health Systems Plan and is referenced when appropriate.

2.400 Utilization of National and State Priorities

Problem areas for special consideration are identified at the national or state level by the preceeding sections of Chapter 2.000. Local health and health service concerns have been studied by the MAHSA staff. An areawide consumer study[6] conducted in November and December 1976 produced the items listed in Table 2-1, page 2-8. These items are listed in priority order as determined by the

---

[5] *An Inventory of Statewide Needs and Priorities Relating to Health*, prepared by the State Health Planning and Development Agency, Missouri Division of Special Services, Missouri Department of Social Services, 1976.

[6] *Mid-America Health Systems Agency Consumer Input Study*, a report to the MAHSA Plan Development Committee, January 1977.

consumers participating in the study. A similar study of public official concerns was carried out in March 1977, and results are summarized in Table 2-2, page 2-9.

The various areas of concern identified at the federal, state, and local levels have considerable overlap and can be combined into a single list of items. The areas of concern are listed below in Section 2.410 and guide the content of the following chapters of the HSP. They are not the HSP priorities, but are used in the development of area health priorities.

2.410 *Areas of Concern for Health Planning*

The following areas of concern have been identified as requiring special attention in the HSP. These items are not listed in rank order. Table 2-3, page 2-10, gives a cross-reference of these items to federal health priorities, state health priorities, and local consumer concerns.

(a) Medically Underserved Populations

The problem of medically underserved populations appears in a variety of types of services and in different geographic areas. Analysis is required to determine the actual problems, but general concerns are clear:

- A shortage of primary care physicians in rural areas and economically depressed areas.
- Insufficient care for convalescent and functionally limited persons, including a shortage of nursing home and home health care.
- Unavailability of emergency services locally, including transportation and treatment.

(b) Availability of Services

A number of perceived needs about local availability of services have been expressed by consumers. Anal-

ysis will be required to determine whether the problems relate to service shortage or service accessibility and distribution:

* Hospital services in close proximity to all areas.
* Public health services, including prevention and detection, in places accessible to all of the population needing them.
* Consumer health education services, especially for young persons.
* Mental health services locally available are desired by consumers, including special programs for drug abuse, alcoholism and child abuse education and counseling.
* Nursing homes near homes and families of clientele.
* General preventive services, including health education programs, should be promoted throughout the service population.

(c) Service Delivery System Improvements

Most of these items come from the federal priorities. The following specific areas are included:

* Multi-institutional coordination or consolidation of institutional health services. Included are obstetric, pediatric, emergency medical, intensive and coronary care and radiation therapy services.
* Development of medical group practices, health maintenance organizations and other organized systems for the delivery of health care.
* Multi-institutional systems for sharing support services.
* Development of geographically integrated systems for providing various levels of institutional care.

- Promotion of quality of care assurance systems.
- Increased training and use of physician assistants.

(d) Cost and Financing of Health Care

Health care costs are a major concern of local consumers and also are emphasized in PL 93-641. These concerns include:

- Increasing costs of all medical and health services.
- Special health care financing problems for many persons not qualified for group or government health financing systems.
- Problems of providing health care for indigent persons.
- Improved and uniform cost accounting and simplified reimbursement systems for health care institutions.

(e) Non-Medical Health Promotion Activities

Social and environmental factors beyond the control of the health service system are important to the health of the population, including:

- Environmental factors such as air and water quality, industrial hazards, etc.
- Personal abusive health behaviors, including smoking, overweight, etc.
- Stressful social environment.
- Nutritional practices and resources.

(f) Direction and Regulation of Health Services

- Increased consumer participation in health service planning.
- Increased public control of the development of health services.

TABLE 2-1

MAHSA CONSUMER HEALTH CONCERNS[1]

Priority Rank	*Item*
1	Cost of Health Care
2	Financing Systems for Health Care
3	Need for Local Physicians
4	Health Services for the Elderly
5	Health Education Services for the Public
6	Acceptability of Health Care
7	Local Emergency Services
8	Hospital Services Locally
9	Public Health Services—General
10	Family Planning, VD Clinics, Sex Education
11	Lack of Nursing Home Care
12	Accessibility of Health Services
13	Lack of Mental Health Services
14	Sanitation Enforcement
15	Alcohol and Drug Abuse Services
16	Lack of Communication Between Consumers and Providers
17	Child Abuse
18	Need for School Nurse Services
19	Immunization of Children
20	Nutrition/Home Services
21	General Ambulatory Services

[1] *Mid-America Health Systems Agency Consumer Input Study*, a report to the MAHSA Plan Development Committee, January 1977.

TABLE 2-2

HEALTH ITEMS FROM PUBLIC OFFICIALS[a]

Group 1—State and Regional

Problem

R-1 High cost of health services.

R-2 Lack of "teeth" in health facilities planning and regulation.

R-3 Availability of health professionals in low and moderate income areas and rural areas.

R-4 Federal and state eligibility requirements that keep the "near poor" from receiving care.

R-5 High and escalating costs of medical education and training of health professionals.

Group 2—County Officials

C-1 Need an exact definition of indigency (as related to the provision of health services).

C-2 Need to determine what services are available from all levels of government and to eliminate duplicative and ineffective services.

C-3 Need medical training center north of the Missouri River.

C-4 Medical care is too expensive for consumers and government providers.

C-5 Consolidation and coordination of health care is absent and there is no mechanism to provide such.

---

[a] The top five items from each list are given here. Complete lists may be obtained from: MAHSA Plan Development Section, 20 West 9th Street, Suite 715, Kansas City, MO 64105.

HEALTH ITEMS FROM PUBLIC OFFICIALS (Continued)

Group 3—City Officials

M-1 Access to and provision for indigent health care (including home health care and ambulatory services).

M-2 Shortage (or distribution problems) of emergency medical services (including communications, 911 program, transportation, and facilities).

M-3 Availability of all medical services in rural areas.

M-4 Shortage of nursing homes (as measured by availability, acceptability, affordability and appropriateness).

M-5 Shortage of hospital beds (as measured by availability, acceptability, accessibility, affordability and appropriateness), especially in Independence. (Need more physician participation in the decision making process.)

M-6 High cost of health insurance for low to middle income persons and families.

TABLE 2-3

SOURCE OF AREAS OF CONCERN IN HEALTH PLANNING

Area	Source			Public Official [12]		
	Federal [9]	State [10]	Consumer [11]	Regional	County	City
A. Underserved Populations	a	e	3, 7, 11	3	3	1
B. Availability of Services	j	c, f	4, 5, 8, 9, 10, 12, 13, 15, 17, 18			2, 3, 4, 5
C. Service Delivery System	b, c, d, e, f, g		6, 19, 21		2,5	
D. Cost and Financing	i	a	1, 2	1, 4, 5	1, 4	6
E. Health Promotion	h	b, d	5, 14, 20			
F. Planning and Control			16	2		

[9] List of priorities from PL 93-641, page 2-2.
[10] Kansas priorities, page 2-3.
[11] Consumer health concerns, Table 2-1, page 2-8.
[12] Public officials lists, Table 2-2, page 2-9.

5.000 INTRODUCTION

MAHSA's health service system is addressed in this Chapter. The service system is presented by describing desired system characteristics and comparing them with the existing service system. Whenever there are differences between the desired system and the existing system, these differences are analyzed to determine whether or not they present problems.

Each identified problem is examined for cause and possible solutions, and corresponding goals to effect betterment are developed. Chapter 6.000 of this document elaborates the goals with objectives and potential long-term actions for each problem area.

The desired system for this health service area is based on national, regional and local standards and comparison data, as well as community values and Agency policies. The framework for describing the health service system is displayed in Appendix C, Health Service Categories for Health System Description. The major categories are:

(a) Community Health Promotion and Protection

(b) Prevention and Detection

(c) Diagnosis and Treatment

(d) Habilitation, Rehabilitation and Maintenance

(e) Personal Health Care Support Services

The initial HSP does not include all service categories. Early in the development of this HSP, the Agency recognized that analysis of the entire health delivery system was not possible given the limited resources (time and money) available to the Agency. A two-stage process was utilized to determine which elements would be addressed in the first HSP. The first stage was identification of those elements or activities which would be the subject of the Agency's regulatory or review activities. At a minimum,

those elements included most licensed health care institutions and categorical funding areas. The second stage involved examining those areas requiring regulatory or review activities and their relationship to the leading health problems as identified by the area's consumers and elected officials.

A close match existed between the regulatory activities and the problem list. Of the top five problem areas, the high cost of medical care, financing of medical care, and medical care for the elderly tie directly into regulatory activities in that the institutionalization of patients accounts for the largest single portion of all health care dollars and costs.

The development of the HSP over a period of time will represent a process of expanding content and increasing integration of the HSP with each yearly revision.

The *Community Health Promotion and Protection* section of this Chapter includes a section titled Consumer Health Education. The policies in Chapter 1.000 and problems in Chapter 2.000 of this HSP indicate that this category is especially important and that consumer health education is the only content area not currently addressed in a systematic plan by some area or regional agency.

Prevention and Detection services are not included in the system description although immunization is covered in the health status chapter and a system-related goal is developed. Prevention and detection services will be developed in subsequent updates of the HSP, and are included in Chapter 9.000, Areas for Future Consideration.

Diagnosis and Treatment have received major emphasis in this Plan. The following areas are included:

(a) Material and Child Care

(b) Acute Inpatient Care Services

(c) Diagnostic Radiology

(d) Emergency Medical Services

(e) Mental Health Services

Some of these areas will be elaborated upon considerably in HSP updates. Dental Services and Primary Care Services (other than those included in the above sections) will be added. Chapter 9.000 also provides details of future Agency planning activities in these areas.

Habilitation, Rehabilitation and Maintenance Services are presented in two sections:

(a) Long-Term Care

(b) Rehabilitation Services

These sections, particularly Rehabilitation Services, will be developed more completely in future HSPs and are listed in Chapter 9.000.

Personal Health Care Support Services are considered only as they relate through other categories in the system (e.g., acute inpatient care services). This section will be developed in the future.

The planning efforts for each service consider six criteria categories:

- availability
- accessibility
- acceptability
- quality
- continuity of care
- cost

These criteria, combined with an analysis of the need for each service, provide a basis for development of goals and priorities within each service category. One of these criteria—cost—also requires special consideration with respect to the system as a whole. The impact on health and other aspects of life from the overall cost of health care must be considered. In addition to the total cost of health care, the relative costs of various components, and amounts allocated to them, reflect the priorities of the community and country in the area of health and health care.

Health Care Costs

The growth of total health care expenditures was recognized as a concern at local, state and national levels in Chapter 2.000. Total expenditures have increased faster in the health sector than for the economy as a whole. This situation can be shown by total expenditures as a percent of gross national product (GNP):

Year	*Total Expenditure*	*% of GNP*	*Per Capita Amount*
1955	$ 17,330 (Millions)	4.5	$103.76
1960	25,856	5.2	141.63
1965	38,892	5.9	197.75
1970	69,201	7.2	333.57
1974	106,321	7.8	495.01
1976	139,312	8.6	637.97

Source: Social Security Bulletin, April 1977

In the two years after price controls were lifted from the health care industry, health care expenditures rose $33 billion, an increase of 31 percent. The economy as a whole grew much slower during this period with total GNP increasing 18 percent from 1974-1976.

Personal health care expenditures increased $29 billion. (Those items included in personal health care expenditures

are shown in Table 1, Appendix D.) The factors responsible for the increased personal health expenditures have varied since 1950.

Source of increase	1950-65	1965-71	1971-74	1974-76
	Amount of increase (in billions)			
Total	$23.1	$33.7	$24.1	$29.1
Price	10.1	16.8	10.4	22.8
Population	4.9	3.0	1.9	1.7
Changes in health care system	8.1	13.9	11.8	4.6
	Percentage distribution			
Total	100.0	100.0	100.0	100.0
Price	43.8	49.9	43.1	78.3
Population	21.0	8.9	7.9	5.7
Changes in health care system	35.2	41.2	49.0	15.9

Source: Social Security Bulletin, April 1977

Since 1974, price inflation has been the primary reason for the expanded personal health expenditures, accounting for 78.3 percent of the increase. Population growth contributed only 5.7 percent. The remaining 15.9 percent was a result of both quality and quantity changes in the health care system. Changes in medical technology and treatment have altered the composition of services used. Removal of financial barriers and an increase in the supply of services have resulted in increased utilization.

The Consumer Price Index (CPI) for the Kansas City area includes an index for medical care and a sub-category for medical services. The medical services component includes hospital service charges and professional services. Medical care includes both medical services and drugs and prescriptions. (Tables 2 and 3 in Appendix D show the medical care and medical services components of the Consumer Price Index for recent years.) The following table shows the CPI for selected years for the Kansas City area.

Consumer Price Index—Kansas City Area

Year	*Medical Care*	*Medical Services*	*All Items*
1955	58.7		78.8
1960	74.8		86.9
1965	88.2		95.5
1970	117.0	120.2*	115.8
1975	160.5	169.6	157.9
1976	174.1	184.6	166.5

* Medical Services component of the Medical Care Index was developed in 1966.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

The 1976 CPI for medical care in the Kansas City area rose 8.5 percent over the 1975 value, while the medical services portion increased 8.8 percent. The overall CPI for the Kansas City area (all items) rose only 5.4 percent. Thus, health care prices are rising faster than other prices, just as total expenditures for health are increasing at a faster rate than expenditures in other segments of the economy.

Increases in price, total expenditures, and relative share of national economic resources have occurred with a changing pattern of payment for personal health care expenditures.

Source of Payment

Personal Health Care Expenditures
(Percentage distribution)

		Third Party Payments			
Year	*Direct Payments*	*Total*	*Private Health Insurance*	*Government*	*Philanthropy/ Industry*
1960	55.3	44.7	20.7	21.7	2.3
1970	40.4	59.7	24.0	34.2	1.5
1976	32.5	67.5	26.0	40.2	1.3

Source: Social Security Bulletin, February 1975, April 1977

Federal expenditures for health have been directed almost entirely to medical care intervention. The 1976 distribution of federal expenditures for health was as follows:

Health Care System	92%
Environment	5%
Human Biology	3%
Lifestyle less than	1%

Source: *The Federal Health Dollar 1969-1976,* Center for Health Policy Studies, National Planning Association, Washington, D.C., 1977

Data are not available for private expenditures for determinants of health other than for medical care. To adequately assess the impact of all determinants of health on the health status of the population, additional data relating to the price and total cost of both private and government expenditures for all aspects of health care are needed.

As expenditures in all areas of health have increased rapidly in the past several years, an ever growing share has been paid for medical care services. Of personal health care expenditures in 1960, 37.4 percent were paid for hospital care. By 1976, the total for hospital care had increased six and one half times and represented 46 percent of personal health care expenditures. During the same time period the amount spent for nursing home care increased from 1.9 percent to 8.8 percent of personal health care expenditures. (The total amount and percent of personal health care expenditures for hospital and nursing home care for selected years is shown in Table 4, Appendix D.)

The major causes of death and disability indicated in Chapter 4.000 are known to be as strongly influenced by lifestyle and environment as by medical care intervention. To the extent that health expenditures support medical interventions which result in small benefits when disease and disability are more clearly related to the influence of en-

vironmental conditions and lifestyles, resources should be directed to alternatives of nonmedical care.

The problems of total cost and allocation of resources to health will be addressed by applying the following policies in the development of priorities and action plans in the HSP:

(a) Total health care expenditures should not increase to more than 10 percent of GNP by 1983.

(b) Total resources allocated to health care in MAHSA's area should not increase more than 15 percent by 1983.

(c) The annual rate of increase in the medical care and medical care services components of the Consumer Price Index for the Kansas City area should not exceed the rate of increase for all items by more than seven percent.

(d) Total expenditures for hospital services should not increase at a rate more than the percent increase in the Medical Care Services component of the Consumer Price Index for the Kansas City area.

(e) Increased expenditures should be directed to the following areas:

1. Extension of services to all individuals through removal of financial barriers and barriers relating to accessibility and acceptability, as opposed to increased technology and intensity of services.

2. Prevention of health problems resulting from altered lifestyles and improved environmental conditions.

5.000 ACUTE INPATIENT CARE SERVICES

5.100 Problem Identification—Acute Inpatient Care Services

This section of the Health Systems Plan addresses acute inpatient care services in 35 of the area's 38 hospitals.[1] Total acute care services include medical/surgical services, obstetrics, pediatrics, and acute physchiatric and alcohol beds within non-federal community hospitals. A general overview of these services will be given with special attention paid to medical/surgical services (ages 15+ and ages 0-14), and psychiatric services. Other sections of Chapter 5.000 deal with obstetrical services.

This component is based upon MAHSA's six planning policies presented in Chapter 1.000 and the policies dealing with the redirection of health care resources presented in the Introduction to Chapter 5.000. All demand and utilization rates presented in Availability—Acute Inpatient Care Services, Sections 5.112 and 5.122, are based upon discharge, admission, patient days and occupancy rates of MAHSA area community hospitals. Current, usable patient origin information is unavailable at this time. Previous studies have shown 11.7 percent of the area's admissions are patients with residencies outside of the eight-county area.[2] All utilization projections assume that the 11.7 percent figure will remain constant.

The estimated service requirements are based upon the 1975 utilization of acute inpatient care services. Two age

---

[1] The remaining three hospitals are the Rehabilitation Institute and the two Veterans Administration Hospitals (Leavenworth, Kansas and Kansas City, Missouri). Representatives from VA hospitals have participated in a "role and scope" planning effort within the VA system. MAHSA will utilize that plan after it is approved.

[2] *Hospital Discharge Study*, 1971, Mid-America Comprehensive Health Planning Agency, Kansas City Area Hospital Association, Kansas City Blue Cross Plan.

specific use rates for acute medical/surgical services have been developed: ages 0-14 and ages 15+.

5.110 *Desired Health System—Acute Inpatient Care Services*

5.111 *Cost—Acute Inpatient Care Services*

The cost of hospital care is influenced by at least the following 10 factors:

(1) increases in technology;

(2) intensity of services rendered;

(3) patient mix of the hospital;

(4) the extent of the hospital's teaching efforts;

(5) the hospital's market basket (i.e., food, energy, supplies, malpractice/liability insurance, personnel, professional fees and contracts);

(6) size of hospital units necessary for efficient operation;

(7) nature of third party reimbursement programs;

(8) cost containment efforts;

(9) total amount and rate of capital expenditures; and

(10) physician admission and utilization patterns.

The collective effect of these factors will be measured by indicators such as per diem charges, per case cost, and the amount of personal health care expenditures devoted to hospital care at national and local levels.

The 10 factors will be managed in a manner such that: 1) national hospital care expenditures will account for 46 percent or less of total personal health care expenditures; 2) hospital care expenditures in the MAHSA area will have the same or smaller percentage of total personal health

care expenditures by the end of 1982 in the Kansas City area as was experienced in 1976. This will require that:

(a) Implementation of new technology be carefully and conservatively approached;

(b) The reimbursement system promote appropriate utilization of hospital services, provide positive incentives for efficient institutions, actively encourage utilization of less costly but equal quality alternatives to inpatient care, and develop uniform reimbursement programs;

(c) Cost containment efforts designed to make the fullest use of existing facilities be implemented;

(d) Capital investment in institutions be controlled by an appropriate review agency; and

(e) Physician practice patterns regarding utilization of hospital services and admission patterns be controlled by an appropriate utilization review mechanism.

Uniform hospital statistical reports should exist so that meaningful hospital-to-hospital and year-to-year cost and utilization comparisons can be made.

5.112 *Availability—Acute Inpatient Care Services*

Determination of availability of acute care services will be calculated using the following indicators.

Indicator: Occupancy Rate [3]

---

[3] Occupancy rates are adopted from guidelines established by appropriate professional societies and Hill-Burton programs.

Desired Level:	85 percent—all beds 90 percent—medical/surgical, ages 15+ 75 percent—medical/surgical, ages 0-14 85 percent—psychiatric, all ages
Indicator:	Admission Rate—Admissions/1,000 Population [4]
Desired Level:	(All Services) High—200.2 admissions/1,000 population Low—1975 admission rate of 182.4 admissions/1,000 population.
Indicator:	Average Length of Stay [5]
Desired Level:	(All Services) 7.65 days
Indicator:	Use Rate—Patient Days/1,000 Population [6]
Desired Level:	(All Services) High—1,502 days/1,000 population Low—1975 use rate of 1,396 days/1,000 population.

---

[4] A range is selected in recognition of the Agency's desire to slow the historical rise in admission rates and based on the realization that achievement of an admission rate less than 1975's by 1983 is impractical.

[5] The desired level was established as 7.65 days due to uncertainty over the effects of changing medical practice, new financial restraints and increased regulatory activities.

[6] See footnote No. 4.

Medical/Surgical: Ages 0-14—1975 rate of 355 days/1,000 age-adjusted population
Ages 15+—1975 rate of 1,583 days/1,000 age-adjusted population

Psychiatry: All ages—94 days/1,000 population

The formula used to calculate the required number of beds will be either:

$$\text{Beds Required} = \frac{\text{Use Rate} \times \text{Projected Population}}{\text{365 Days} \times \text{Desired Occupancy Rate}}$$

OR

$$\text{Beds Required} = \frac{\text{Admission Rate} \times \text{Average Length of Stay} \times \text{Population Projection}}{\text{365 Days} \times \text{Desired Occupancy Rate}}$$

Application of the two formulas results in the bed need calculations for total acute care beds as shown in Appendix F, Table 10. Depending on the population projections, total acute care bed requirements in MAHSA's area by the end of 1982 will range from a low of 6,036 beds to a high of 7,651 beds. Where information is available both formulas will be used to determine bed needs since USE RATE = (ADMISSION RATE × AVERAGE LENGTH OF STAY). Since the average length of stay figure is usually difficult to obtain, the use rate formula normally will be used.

Age-specific medical/surgical and psychiatric bed need projections are shown in Appendix F, Table 5.

The area's total bed needs are presented with both high and low projections. The low projection assumes that at the end of 1982 the total population and the admissions or use rate will be the same as in 1975; the high projection uses MARC population projections for the end of 1982 and the

admission/use rate which is a continuation of the trend from 1971-1975.

The projected high admission/use rate will be realized if:

(a) large groups of the population in 1975 are not receiving services due to financial barriers and those financial barriers are removed by the end of 1982;

(b) the average age of the population increases significantly by the end of 1982;

(c) MAHSA area hospitals become major referral centers for other geographic areas;

(d) alternative levels of care are not made available (e.g., outpatient surgery, skilled nursing home services, home care programs);

(e) alternative financing programs for operations and capitalizations are not made available;

(f) the type of care traditionally rendered in an acute care setting is not altered;

(g) effective utilization review programs are not provided;

(h) solutions to the need to practice defensive medicine are not found;

(i) the personal lifestyles of area residents do not change in a manner which contributes to decreasing the unnecessary use of acute care facilities; and

(j) physician utilization of hospital services and admission patterns are the same in 1982 as existed in 1975.

A reduction by the end of 1982 in the admission/use rate trend will be realized if:

(a) large groups of the population are receiving services in 1975 and new financial barriers are imposed by the end of 1982;

(b) the average age of the population does not increase significantly by the end of 1982;

(c) MAHSA area hospitals do not become major referral centers for other geographic areas:

(d) alternative levels of care are made available;

(e) alternative financing programs for operations and capitalizations are found;

(f) the type of care rendered in an acute care setting is altered (e.g., preadmission testing, less emphasis on diagnostic admissions);

(g) effective utilization review programs are increased;

(h) solutions to the need to practice defensive medicine are found;

(i) the personal lifestyles of area residents change in a manner which contributes to decreasing the unnecessary use of acute care facilities; and

(j) physician utilization of hospital services and admission patterns change by the end of 1982.

A range in the number of total hospital bed services needed has been provided due to the uncertainty of the effects the preceding factors will have on utilization and demand for acute inpatient care.

5.113 ***Accessibility—Acute Inpatient Care Services***

The need for marshalling adequate resources to provide acceptable quality of care, and the expensive nature of acute inpatient care services, place considerable constraints

on future geographic distribution of acute inpatient services. Factors such as economics of scale, financial arrangements, and geographic and architectural barriers must be considered when accessible inpatient care is planned to ensure that no one portion of the area's population is more than 60 minutes away from acute medical care.

In determining accessibility of acute inpatient care, the following must be considered:

(a) total availability of acute care services;

(b) degree of utilization of all bed services;

(c) size of units which can maintain efficient operation;

(d) geographic distribution of the population;

(e) specialized needs of the area's sub-populations;

(f) the existence of geographic factors which act as deterrents to residents requiring a service: these factors include but are not limited to transportation networks, river and bridge locations, and general economic or market trade areas;

(g) architectural factors associated with the physical structures housing acute inpatient care services (all of the area's acute care institutions must meet the appropriate state and federal codes for licensure and safety);

(h) the nature of specialized services and the population base required to generate sufficient volume to maintain appropriate quality standards for these services; and

(i) the existence of financial arrangements which serve as deterrents to individuals requiring acute inpatient care: the elimination or minimization of such barriers recognize the individual's right to access each level of care as medically necessary.

5.114 *Quality—Acute Inpatient Care Services*

All of the community hospitals in MAHSA's health service area should meet and maintain the appropriate national, state or local standards for medical care.

The area's two Professional Standards Review Organizations (PSROs) should be utilized to measure the quality of care in the area's acute inpatient care institutions.

Each hospital should continue to increase and support ongoing efforts to monitor and upgrade its quality of care. Procedures and methodologies should be established to evaluate the outcome of the care the patient receives in addition to the process utilized to deliver that care.

5.115 *Continuity—Acute Inpatient Care Services*

Acute inpatient care institutions should become a major focal point of a health care system which assures continuity of health care at all levels. Such a system would result in a stratification of all components of the health delivery system with a high level of coordination between and among the major sponsors of care.

The organizational structure of acute care institutions should be responsive to acceptance of a changing role for hospitals if the hospital entity is to become one of the major coordinating forces in an integrated delivery system. By the end of 1982, the hospital should provide highly specialized inpatient services, with less emphasis on primary diagnostic and treatment services provided on an inpatient basis. The hospital should become a facilitator of a coordinated system which delivers care to patients at the lowest, most elementary level possible consistent with patient needs and quality of care considerations.

The development of such a system which provides for continuity of care to the patient is predicated on two key elements:

(a) each hospital in MAHSA's service area having a clearly defined role relative to the other components of the health care system; and

(b) the formation of one or more organized, formal mechanisms to effect efficient utilization, allocation, and coordination of acute care programs and resources.

5.116 *Acceptability—Acute Inpatient Care Services*

Community acceptance of acute inpatient care will depend entirely on the patient's and community's cultural backgrounds. The patient's and community's knowledge and acceptance of the need for acute care services are as important as the patient's acceptance of the care finally received.

Acceptance of acute care services should be predicated on the impact of care on the patient's illness as opposed to the hospital's economic benefit to the community.

5.120 *The Current Acute Inpatient Care System*

5.121 *Cost—Acute Inpatient Care Services*

Hospital Expenditures—The proportion of the national personal health care dollar devoted to hospital care increased from 37.4 percent in 1960 to 46 percent in 1976 (Appendix D, Table 4). Similar statistics for MAHSA's health service area are not available.

Total expenses incurred by all hospitals have increased during the past five years with the total expenses for hospitals in MAHSA's area increasing 63.5 percent from 1971 to 1975: $206,587,000 in 1971 to $337,813,000 in 1975 (Appendix F, Table 1). Expenses per adjusted inpatient day in community hospitals in the MAHSA region were almost identical to the national average in 1975 ($133 to $134).

Plant Assets—Total plant assets for most of the area's community hospitals have increased by 147 percent from 1971 to 1975 (Appendix F, Table 1). The plant assets per adjusted daily census have increased 114.3 percent locally as compared to national and metropolitan averages of 44.6 percent and 45.4 percent respectively. The MAHSA region has ranged from 1.9 percent to 50.2 percent higher than other metropolitan areas in average plant assets per adjusted daily census (Appendix F, Table 2).

Manpower—Staffing patterns of the area's community hospitals considering full-time equivalents (FTEs) per adjusted average daily census are 3.17 for the area, 2.71 for this census region, and 3.00 for the United States (Appendix F, Table 3).

Patient Expenses—Area hospitals had an average daily service charge of approximately $80 for a semi-private room, compared to the U.S. average of $90.93 in 1976.[7] Billed charges per day in area hospitals increased by more than 50 percent from 1971 through 1975.[8] The per case charges were approximately $760 in 1971 and $1,125 in 1975, a 48 percent increase. Hospital charges or expenses are not routinely available by admitting or discharge diagnosis.

Cost Containment—Information concerning cost containment efforts by area community hospitals is difficult to document. It is known that various services and programs exist which the hospitals utilize to varying degrees in an effort to contain costs while providing needed community services. These programs include preadmission testing, outpatient facilities including ambulatory surgical centers, and alternatives to inpatient care for patients with pre-acute

---

[7] Survey of Semi-Private Room Charges as of January, 1977, Health Insurance Association of America.

[8] Blue Cross Plan of Kansas City, 1964 through 1976.

and post-acute conditions (rehabilitative care, including some home care programs).

Information is not available concerning the hospitals' participation in programs designed to increase the use of existing facilities (increased work week in major support services, efficient scheduling of operating suites and other diagnostic services, etc.).

5.122 *Availability—Acute Inpatient Care Services*

Total Acute Care Capacity—Total acute care capacity includes acute medical/surgical, pediatric, obstetrical and psychiatric bed services as well as intensive care and coronary care bed services. Bassinet and overflow beds are excluded and are not addressed.

Availability of acute care bed services considers an acute care bed irrespective of the geographic location of the bed or individual requiring it.

MAHSA's health service area has a total of 32 acute care general, non-federal community hospitals, two Veterans Administration Hospitals, three psychiatric hospitals and one facility devoted entirely to rehabilitation services (Appendix F, Table 6 and Map).

These hospitals had a total of 7,334 licensed beds in 1975 with 6,676 beds staffed for service. The over-all occupancy rate for licensed beds was 69.5 and 76.4 percent for staffed beds. The national, regional and metropolitan area occupancy rates were 75.0, 70.9, and 77.4 percent, respectively. During 1975, area hospital occupancy rates ranged from a low of 30.2 percent to a high of 88.2 percent (Appendix F, Table 7).

The community acute care bed-to-population ratio for MAHSA's health service area was 4.97 staffed beds per 1,000 population and 5.4 licensed beds per 1,000 population (Table 9, Appendix F). Comparable ratios for staffed beds were:

Missouri	5.3 beds/1,000 population
Kansas	5.7 beds/1,000 population
West North Central	5.8 beds/1,000 population
United States	4.5 beds/1,000 population

The admission rate (admissions per 1,000 population) for MAHSA's health service area can be found in Appendix F, Table 4. The area's admission rate has been consistently higher since 1971 than the rate for the United States as a whole. The admission rate for the North Central Region has increased at a pace faster than MAHSA's to the point that the North Central Region's rate exceeded MAHSA's rate in 1975.

The number of inpatient days per 1,000 population remained relatively constant in MAHSA's service area between 1972 and 1975, increasing by only four percent. Nationally the increase was 3.9 percent. Regionally the increase was 6.7 percent. In 1975, MAHSA's inpatient days per 1,000 population was 15.4 percent above the national rate but six percent below the regional rate (Appendix F, Table 4).

Table 4, Appendix F, indicates that the average length of stay for all beds and age groups declined by five percent from 1971 to 1975. This five percent decline is greater than that experienced nationally, in the region, and in other U.S. metropolitan areas. MAHSA's length of stay has been almost identical to the national average and generally below that shown for the region or other metropolitan areas.

Acute Medical/Surgical Bed Service Capacity—In 1975 there were 5,261 medical/surgical beds available in MAHSA's service area. Occupancy rates ranged from a low of 31.6 percent to a high of 92.5 percent. The average occupancy rate was 82.1 percent. The average length of stay ranged from 6.1 days to 9.5 days. The average length of stay was 8.2 days. Total beds, occupancy rates and length

of stay figures include intensive care and coronary care unit beds (Appendix F, Table 7). Comparable national and regional statistics are not available. Inpatient days per 1,000 population for medical/surgical beds for ages 15+ was 1,575 in 1974 and 1,583 in 1975 (Appendix F, Table 5).

A program by program analysis is not available for all services included in the medical/surgical bed capacity with two exceptions: end-stage renal dialysis and open heart surgery.[9,10] Both analyses indicate that the existing programs are sufficiently available to the population.

Pediatric Acute Care Bed Service Capacity—A total of 602 beds are formally designated as pediatric care beds and pediatric care also is available through other medical/surgical beds in the MAHSA region. Nineteen of the area's hospitals reported formal organized pediatric services. The occupancy rates ranged from 31.8 percent to 77.7 percent in a two-bed unit. The only hospital devoted exclusively to pediatric care reported an average occupancy of 69.6 percent. In 1974, admission/1,000 population ages 0-14 were 358/1,000 and 355/1,000 population in 1975. 1974 and 1975 average lengths of stay were 5.3 and 4.9, respectively (Appendix F, Tables 5 and 7).

Psychiatric Acute Care Bed Service Capacity—In 1975, there were three hospitals devoted exclusively to psychiatric care. Ten of the area's community hospitals reported organized psychiatric units. There were a total of 576 psychiatric beds, with an additional 38 beds devoted to alcohol programs. Occupancy rates ranged from a low of 50.4 percent to a high of 115.6 percent (Appendix F, Table 7). The 1975 use rate was 94 days/1,000 population (Appendix F, Table 5).

---

[9] *End-Stage Renal Disease Study-Dialysis and Transplant Plan*, Mid-American Comprehensive Health Planning Agency, July 1975.

[10] *Open Heart Surgery Plan*, Mid-America Comprehensive Health Planning Agency, April 1976.

5.123 *Accessibility—Acute Inpatient Care Services*

Financial Accessibility—Nationally, about 92 percent of the expenditures for acute inpatient care were from third party payors.[11] The remaining eight percent were paid directly by the consumer. Most people over age 65 are covered by at least Medicare. Approximately 85 percent of the rest of the population are at least partially covered by some type of hospital care insurance.

A study done by a local group seeking to qualify as a federal health maintenance organization showed that the Kansas City area is about average for health insurance coverage.[12] Most, if not all, of the health insurers in the area reimburse hospital charges in one of three traditional ways: predetermined reimbursement level; negotiated billed charges; and cost. All insurance programs operate on a fee-for-service basis. There is one functioning health maintenance organization operating on a capitation basis. There exists a trend by third party payors to encourage and support alternatives to expensive inpatient care.

Kansas City, Missouri, and Jackson County, Missouri, serve as major sources of operating funds for two area institutions: Truman Medical Center and Truman Medical Center East. This support is designed to help meet city and county obligations to the medically indigent. A similar situation exists between the University of Kansas Medical Center Hospital and the State of Kansas.

Geographic and Architectural Factors—All residents of MAHSA's health service area are within, at most, one hour's travel time to the nearest acute care institution. Due to the Missouri and Kansas Rivers, two sub-areas have geographic barriers to other portions of MAHSA's service area: Clay, Platte, and Ray Counties in Missouri (the

---

[11] Social Security Bulletin, April 1977.

[12] GHAA.

Northland area), and Wyandotte and Leavenworth Counties in Kansas. Three studies have shown that the existence of the two rivers does in fact create distinct economic trade areas.[13,14,15] Hospitals within these areas are new or have been recently replaced or renovated.[16] The only exception is Cushing Memorial in Leavenworth County.

Three counties (Ray, Cass, and Leavenworth) are predominately rural. The hospital in Ray County has recently undergone extensive renovation. Neither Cushing Memorial nor Cass County Memorial has undertaken any renovation. Jackson and Johnson Counties are physically contiguous and economically integrated. No geographic barriers to travel between the two counties exist. The northeast portion of Johnson County and the western one-half of Jackson County are especially oriented economically to each other. Residents of Johnson County south of Interstate 435 are less oriented to the core area. Residents east of Interstate 435 in Jackson County are oriented less to the core area than to their own sub-area.

Due to the existence of the Missouri-Kansas state line, certain state oriented preferences exist. There is also an awareness of community in many municipalities that strongly affects service utilization patterns.

Except for the Medical Center of Independence, Suburban Medical Center, and Parklane Hospital, all hospitals in Johnson and Jackson Counties have just recently completed renovation, replacement or expansion programs. Suburban, Parklane, and the Medical Center of Independence will

---

[13] *Urban Research Service Report*, February 1973.

[14] *Transportation Study*, Missouri Department of Highways and Mid-America Council on Governments, 1971.

[15] *Hospital Discharge Study*, 1971, MACHPA, KCAHA, Kansas City Blue Cross Plan.

[16] Capital Expenditures Files, Mid-America Health Systems Agency.

complete their respective construction programs by 1979. Although Menorah Medical Center has expanded recently, the hospital has indicated a need for extensive renovation of its older ancillary services departments to meet safety code requirements.

Appendix F, Table 8, indicates the distribution of hospital beds by geographic or political boundaries and shows that hospital beds are not distributed according to the population.

Residents of Clay, Jackson, Johnson, and Platte Counties account for hospital discharges in roughly the same proportion as the population distribution. Wyandotte County residents account for a higher percentage of discharges than the percent of the population residing in Wyandotte County. Leavenworth, Cass, and Ray Counties account for a smaller percentage of the hospital discharges than their respective percentages of the population.[17] Imperical information is not available concerning the economic impact of the hospital's size on patient charges.

5.124 *Quality—Acute Inpatient Care Services*

Hospitals in MAHSA's service area all make use of the traditional committee structure for evaluation and monitoring quality of care within the institution.

The MAHSA area has two Professional Standards Review Organizations: the Northwest Missouri PSRO which serves the five Missouri counties and the Kansas Medical Foundation which serves the three Kansas counties. Both organizations are still in organizational and start-up phases with the Northwest Missouri PSRO being the most advanced. While the two organizations are interested in

---

[17] MRI Project No. 3983-D, ***A Clinical Input-Output Study for the Kansas City Metropolitan Region,* 1975.**

quality, their initial thrust obviously is designed to help control the unnecessary expenditure of federal reimbursement funds.

With the exception of four hospitals of less than 100 beds, all hospitals in MAHSA's service area are accredited by either the Joint Commission on the Accreditation of Hospitals or the American Osteopathic Association.

All quality evaluation programs are essentially process oriented.

5.125 *Continuity—Acute Inpatient Care Services*

Community-wide programs designed to coordinate the medical care each inpatient receives are essentially nonexistent. By the nature of the area's hospital and physician practice patterns, the responsibility for coordinating a patient's care resides mainly with the patient and physician rather than with the institution. Most area hospitals have organized discharge planning programs. Most of the hospitals have at least informal referral patterns between institutions, programs, and other levels of care.

None of the hospitals in MAHSA's service area shares a common board of directors. Two have management contracts with either another local hospital or with a national hospital chain. Type of hospital ownership varies: municipalities; churches; proprietary hospital chains; and other private, not-for-profit corporations. All hospitals but one are exempt from ad valorum taxes.

The Kansas City Area Hospital Association sponsors a number of shared programs ranging from a common training program to shared purchasing arrangements and laundry services. Some hospitals participate in a community-wide consortium to coordinate residency programs.

There are no organized communications channels between or among key decision makers in the hospital community

which are specifically designated to coordinate the development of the Kansas City hospital industry.

It does not appear that each hospital in the MAHSA health service area has a clearly articulated role in the community which organizes and integrates each hospital within the various components of the health services delivery system.

5.126 *Acceptability—Acute Inpatient Care Services*

The general acceptability of the area's acute care services is usually expressed in three subjective areas.

The patient's general reaction to the type of care received in the hospital determines one type of acceptability. The patient's reaction usually depends on how long he has waited for care in areas such as the emergency room and radiology department; how "nice" the nursing staff was; and the reaction of the patient's family. For every patient with a low opinion of one hospital, there is another patient with a high opinion. Most problems occur when the patient does not have sufficient knowledge of the hospital's services.

A second subjective area relates to the political acceptability of an institution. Most communities view the hospital's physical structure with pride and see it as a viable economic force for the community. All area hospitals are acceptable to the communities in which they are located.

The third area relates to the acceptability of the acute care service to the medical profession. Osteopathic medicine is a prominent force in the medical community in addition to allopathic medicine. Three hospitals are specifically devoted to osteopathic medicine. The remaining hospitals, while predominantly oriented to allopathic medicine, do not have legal restrictions prohibiting the practice of other areas of medicine.

5.130 *Comparative Analysis—Acute Inpatient Care Services*

Comparison of the existing acute inpatient care services system as of 1975 with the desired system characteristics indicates a number of problem areas—cost, availability, continuity, measurement of quality, and acceptability. Problems with access to acute inpatient care services, regardless of level of care, are not major.

5.131 *Cost—Acute Inpatient Care Services*

Based on the indicators presented in Section 5.111, a trend analysis suggests that hospital care will account for a larger share of personal health care expenditures than is desirable.

At the present time the community does not have the ability to get an accurate estimate of costs for a given type of service from hospital to hospital. A common or uniform reporting system which allows community-wide comparisons of utilization and cost data does not exist.

Estimates of the contribution of new technology, the reimbursement system, lack of fully implemented cost containment programs, and ineffective limitations on capital investments are difficult to ascertain without comparable figures by hospital. However, Appendix F, Table 2, does indicate that the MAHSA area has a higher level of average plant assets per adjusted daily census than the nation, and either Kansas or Missouri. The major increase occurred after 1973 when a building cycle occurred in the area. Such a jump in assets would not have occurred with severe limitations on capital investments.

5.132—*Availability—Acute Inpatient Care Services*

Bed need projections and any surplus of beds are shown in Appendix F, Table 10. With a projected supply of 8,456 total acute care beds, bed need projections range from a low

of 6,036 beds to a high of 7,651 beds. A surplus of from 805 to 2,420 beds is projected to exist in the MAHSA community by 1983. It is more likely that the oversupply of beds will range from 1,772 to 2,244. These projections are based on current utilization rates and population projections for 1983. As the area population did not grow as rapidly between 1970 and 1975 as previously projected, it is unlikely that the population in 1983 will reach the projected figure. Given the projected supply of beds, the occupancy rate could range from 60.3 percent to 76.4 percent. The most likely range is from 62.0 percent to 68.1 percent occupancy (Appendix F, Table 4).

Based on the 1975 use rate, a surplus of beds is projected to exist in medical/surgical and psychiatric beds (Appendix F, Table 5). Specifically, a surplus of 1,445 beds and 83 beds is projected in medical/surgical bed services for ages 15+ and 0-14, respectively. With not all psychiatric bed utilization data available, a surplus of 167 beds tentatively is projected.

Considering the socio-economic data presented in Chapter 3.000, it is not altogether clear why MAHSA's use and admission rates are relatively high.

Possible explanations could include availability of beds, method of medical practice, lack of financial incentives to utilize other levels of care, fee-for-service orientation, or some undetected illness pattern that has not surfaced in available statistics. With the relatively high use of surgical operations, a close examination of the inpatient admissions pattern by type of service may be warranted.

5.133 *Accessibility—Acute Inpatient Care Services*

Appendix F, Table 8, shows that the total supply of beds is not distributed according to the population. A review of Appendix F, Table 7, and the map in Appendix F illustrates both the disparity of bed occupancies and population

distribution. In 1975, the highest overall utilization occurred in the larger hospitals located away from the inner city area of Kansas City, Missouri. Generally, the smaller the hospital and the farther away from the urban and surburban areas, the lower the occupancy rate. The area's two major teaching institutions had lower occupancy rates, partially due to antiquated facilities, and partially (in the case of Kansas University Medical Center Hospital) due to the internal organization of bed units.

The two areas confronting major geographic barriers (the Northland and Wyandotte County) have not experienced accessibility difficulties in terms of bed utilization.

MAHSA's Capital Expenditure Project files indicate that almost all of the area's hospitals are in physical conformance with current licensure laws. Exceptions appear to be portions of Menorah Medical Center, Kansas University Medical Center, all of Downtown Hospital, and possibly portions of Cass County Memorial and Cushing Memorial hospitals.

Surveys and plans done by the Mid-America Comprehensive Health Planning Agency indicate that accessibility to end-stage renal dialysis and open heart surgery programs is not a problem.[18]

With the developing trend toward financing alternatives to inpatient care, barriers to appropriate care at a lowered cost appear to be lessened. Problems in defining the medically indigent are common; these, in turn, may create accessibility problems. A determination of who is responsible for care of the medically indigent needs to be made.

Problems in gaining access to economical health insurance exist for individuals who have either recently retired, are unemployed or layed off.

---

[18] Ibid., MACHPA End-Stage Renal Disease Study, Open Heart Surgery Plan.

Accessible alternatives to some forms of inpatient care are slowly becoming available. Hospitals are formalizing ambulatory surgical programs to the extent that the present capacity is not being fully utilized.[19,20]

5.134 *Quality—Acute Inpatient Care Services*

Information is not available on a community-wide basis which permits an objective evaluation of acute inpatient care quality. However, it is perceived that quality does not appear to be a problem in MAHSA's health service area. The manner in which quality of care is determined (i.e., process evaluation) does not appear to measure or define the expected outcome of care.

5.135 *Continuity—Acute Inpatient Care Services*

Public statements of each individual hospital's role and scope and its manner of integrating its programs and services with the rest of the community are not readily available. MAHSA is aware of several such studies done on behalf of hospitals, but has only one (North Kansas City Memorial Hospital) available at this time.

The problem of community-wide continuity of care exists. Other than MAHSA, there is not a viable mechanism which the hospital community can use to insure an appropriate allocation of resources that is responsive to community needs.

5.136 *Acceptability—Acute Inpatient Care Services*

The major problems associated with this characteristic lie in two areas. First, community leadership evaluates the

---

[19] Mid-America Health Systems Agency Capital Expenditure Files.

[20] *Ambulatory Surgery Plan*, Mid-America Comprehensive Health Planning Agency, July 1974.

acceptability of an acute care institution on the basis of the institution's contribution to the area's economy rather than on the institution's overall impact on the health of area residents. The second problem can be found in the difference between the patient's expectations of the acute care delivery system and the system's ability to meet those expectations. Many patients have a tendency to place inappropriate demands on the hospital system (i.e., the patient seeking to utilize an emergency room for treatment of a common cold).

It is possible that the hospital system should assist the patient as the patient seeks to learn how to effectively utilize the health care system.

5.200 Problem Analysis—Acute Inpatient Care Services

Major Problem: The acute inpatient care system does not function in a coordinated manner which is cost effective in the delivery of acute care services at the most appropriate level consistent with quality standards.

Item #1: Hospital costs and utilization are increasing at a rate which causes expenditures for hospital care to consume an increasing share of all personal health care expenditures. As more resources are allocated to hospital care, fewer overall resources are available to support programs designed to help the individual develop a lifestyle which will decrease the need for acute inpatient care services.

Item #2: Reimbursement systems generally do not promote appropriate utilization of hospital services, provide positive incentives for efficient institutions, actively encourage utilization of less costly but equal quality alternatives to inpatient care, or utilize uniform reimbursement programs. The third party reimbursement system has a direct

impact on the utilization of health care services at all levels. Until proper fiscal incentives are provided which encourage the provision of alternative levels of care, expensive forms of care will continue to be most highly utilized.

Item #3: Active cost containment programs which encourage full utilization of a hospital's support services do not appear to be in common use. Unused capacity of expensive resources can create an unnecessary fiscal burden on the community as a whole.

Item #4: By 1983, a surplus of total acute inpatient care services ranging from 805 beds to 2,244 beds is projected for this area. Surpluses in medical/surgical services for ages 15+ (1,445 beds), ages 0-14 (83 beds), and psychiatry (167 beds) are projected by 1983.

The average per diem billed charge for the MAHSA service area in 1976 was approximately $176. A staffed, but unused hospital bed costs the hospital to maintain. The cost is estimated to be at least 60 percent of the per diem billed charges. Using only 60 percent of the 1976 per diem billed charge as the daily cost of an open but unused bed at the end of 1982, the total annual cost to the community for one surplus bed would be about $38,630 annually. The total cost to the community for the projected surplus beds could range from $31,097,150 to as high as $93,484,600 annually by 1983—the equivalent of $22 to $67 per capita in the MAHSA area.

Other consequences of the projected oversupply of acute care services and beds exist. In 1975, the use rate and admission rate for the MAHSA area were among the highest in the United States. A continuation of the trend will result in an admission rate of more than 200 per 1,000 population by the end of 1982. An examination of the area's socio-economic characteristics does not provide any rational explanation of the high use rate. Due to the projected supply of beds, the possibility exists that the beds, given ade-

quate reserves of nursing and other support personnel, will be utilized. Even with increasing pressure from utilization review programs, the capacity exists, hence, inappropriate admissions may not be discouraged.

The cost of over-utilization is measured by more than just the cost of the hospital stay. The total cost includes the possibility of increased morbidity and mortality in addition to social and emotional costs.

Item #5: There appears to be a maldistribution of acute inpatient care services. Some residents of the MAHSA area may be inconvenienced by increased travel time to reach the nearest acute care hospital. This inconvenience could also have negative consequences in terms of increased morbidity and mortality among those area residents.

Item #6: Availability and utilization of alternatives to inpatient care are limited. Many alternatives to inpatient care that are available are not being fully utilized (home care, ambulatory surgery). It is not altogether clear why many of the hospital-based ambulatory surgery programs are not being fully utilized. The potential demand has been identified. The program capacity exists. Either the physician, the patient, or the hospital administration (or some combination thereof) is not actively encouraging use of the programs.

Item #7: The expected effects of hospital care—as differentiated from other levels of care—has not been defined. A clear determination of whether or not the acute inpatient care system is consistently contributing to the health of the population is not always possible. Consequently, the benefits of the acute care system are not always clear.

Item #8: Patient care is not coordinated among all levels of institutional care. Without effective coordination in all levels of care, the possibility exists that the patient will not receive the appropriate care at the most economical cost.

Item #9: The community does not have an accurate perception of the use and value of the acute inpatient care system. So long as the public's expectations of the acute inpatient care system do not match the system's ability to meet those expectations, inappropriate demands on the system will be met with inappropriate programs and services.

Item #10: Historically, the impact of hospital cost and charges has not been felt by all consumers due to the lack of direct patient-to-provider reimbursement mechanisms. Third party reimbursement programs pay for more than 90 percent of all hospital care. The direct responsibility for payment does not rest with the recipient of care. Consequently, the patient is less concerned with hospital costs primarily due to the fact that he may never know the charges for the care received. Some experts argue that without direct fiscal responsibility, patients may demand care that is inappropriate.

Item #11: Physician practice patterns with respect to hospital services have a major impact on costs and utilization of those services. Effective cost containment in hospitals will require modification in these practices when cost and utilization can be lessened without detrimental effect on quality of care.

5.300 GOALS

5.310 *Goal #1*

Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner.

6.000 LONG-RANGE RECOMMENDED GOALS, OBJECTIVES, ACTIONS AND INTERVENTION STRATEGIES

Introduction

This chapter develops *action plans* from the five-year health status goals presented in Chapter 4.000 and the health systems goals presented in Chapter 5.000. The goals are defined more precisely by *objectives* which are to be accomplished in order to meet them.

The actions suggested have been selected as the most desirable means of accomplishing the goals and objectives listed, which generally are long-range recommendations designed to be put into effect during the next five years.

Selected *strategies* for bringing about the desired actions also are briefly listed. These strategies will be further detailed in the Annual Implementation Plans produced by the Agency each year to implement the HSP.

6.000 LONG-RANGE RECOMMENDED GOALS, OBJECTIVES AND ACTIONS—ACUTE INPATIENT CARE SERVICES

Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards.

6.100 Goal:

Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner.

The following objectives are considered to be of about equal priority. Availability, accessibility and cost issues are so complex and interdependent that solutions for one can-

not be done without equal consideration of the other issues. Cost issues appear to have highest priority. Because of the problem statements presented in Chapter 2.000, cost will continue to be emphasized.

Objective #1

Provide acute inpatient care services in those areas which develop geographic accessibility problems.

(1) Monitor and evaluate potential accessibility problems which may result from market trade areas or geographic barriers in the following areas:

—Areas north of the Missouri River in Missouri (Clay, Platte and Ray Counties)

—Eastern Jackson County

—Wyandotte and Leavenworth County

—Southern Johnson County

(2) Utilizing Certificate of Need legislation and procedures, MAHSA will change the geographic distribution of acute care services only as solutions are found to eliminate the overall surplus of services. Additional acute inpatient service beds will not be added to geographic areas unless the oversupply of beds is reduced and an equal number of beds are removed from service in other areas.

(3) State-oriented preferences will be recognized to the extent possible within the overall available inpatient capacity.

(4) A determination must be made as to whether or not medically indigent patients are unable to receive care due to fiscal barriers in MAHSA's area.

(5) Teaching institutions by their nature create certain accessibility problems. Consideration will be given to those problems.

Impact

Geographic accessibility will be achieved to the satisfaction of residents in the four areas listed. Many if not all of those residents' concerns over convenience will be alleviated. However, such geographic distribution will not be achieved until the overall supply problems are alleviated. A negative impact on the health of the population is not predicted. Additional capital costs to the overall community will not be incurred.

Objective #2

Provide available acute inpatient care services in accordance with projected need requirements (Tables 5 and 10, Appendix F).

Actions

(1) The service need projections set forth in Tables 5 and 10, Appendix F, will be used as a foundation for review of new institutional services and appropriateness review.

(2) The provider community, MAHSA and the general public should work together to seek alternative uses for the projected surplus capacity.

(3) An information system should be developed to accurately report admissions, discharges, length of stay and patient origin data for major service categories and disease diagnoses.

(4) The population of MAHSA's area will be studied in an attempt to determine the reasons for the apparent high utilization of acute inpatient services relative to other areas in the United States.

(5) Acute inpatient care service need projections will be reviewed and updated annually.

Impact

Additional inpatient services will not be added to the community. Consequently, additional capital costs for new or expended facilities will not be incurred so that any price increase will be limited to intensity of care, new technology or inflation. Some patients and families will travel slightly more than others but no population group is more than 30 minutes away from an acute care institution. Additional costs of travel are more than offset by savings incurred by no additional construction.

Objective #3

Establish programs which emphasize measurement of outcome of inpatient care.

Actions

(1) The patient should participate with the physician in choosing the level, type and quantity of inpatient care to be received.

(2) All hospitals should continue to use and upgrade utilization and quality evaluation programs.

(3) The Professional Standards Review Organizations should continue to develop and implement quality review programs which emphasize outcome of patients' care.

(4) Third party payors should develop and implement reimbursement programs and quality assessment programs which emphasize medical care outcomes as well as process.

Impact

The cost implications are unknown. It is anticipated, however, that if the patient works more with the physician in helping to accomplish basic objectives of the patient's

care, the savings in terms of long-term social and financial considerations, are immeasurable. Patient satisfaction will be increased and lower utilization of the overall health care system could result in a perceived higher level of health.

Objective #4

Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index.

Actions

(1) The hospital system should implement new technology in a conservative manner.

(2) Cost containment efforts designed to achieve the most efficient utilization of existing facilities and programs should be implemented.

(3) Capital expenditures by or on behalf of acute inpatient care facilities should be limited only to those expenditures necessary to replace obsolete equipment, to accommodate an increase in the intensity of care, and to reflect an institution's change in patient mix. Capital expenditures for inpatient care services should be undertaken only in those instances which will improve accessibility rather than increase the availability of inpatient beds.

(4) Third party coverage of ambulatory care services should be increased.

(5) Pre-admission testing programs should be actively implemented in MAHSA area hospitals.

(6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made.

(7) Certificate of Need or 1122 review programs, which levy licensure or fiscal sanctions against institutions making inappropriate capital expenditures, should be available in the MAHSA area.

(8) Efforts should be made to determine why the available capacity for ambulatory surgery is not being fully utilized, especially in view of the need for projections done by the Mid-America Comprehensive Health Planning Agency.

(9) Providers, consumers, elected officials and business and labor leaders should explore ways for helping the consumer assume a more direct role in reimbursing providers for the delivery of medical care.

Impact

Cost increases in the health care system will not be any greater than the cost increases in the rest of society. If successful, the overall savings to society in general will more than offset the social cost of increased regulation. Alternatives to inpatient care will be found and implemented. Capital expenditures will be undertaken only to accommodate technological advances and increased intensity of care. Some institutions will expend funds for renovation to meet licensure requirements.

Objective #5

Establish formal mechanisms to effect efficient utilization, coordination and allocation of acute care programs, services and resources.

Actions

(1) Each hospital entity should develop a definition of that hospital's role in the health care delivery system. The role definitions should be developed with the joint efforts of other health care providers in the same market or trade area.

(2) MAHSA and the area hospital association should coordinate efforts to effect the coordination of services.

Impact

If accomplished, all hospitals will work together in a coordinated manner to minimize unnecessary duplication of services. The impact on the area's health would be positive but unmeasurable.

Objective #6

Provide acute inpatient care services which are acceptable in terms of impact on the health of the patient.

Actions

(1) Education programs should be provided which help the consumer understand and utilize the acute inpatient care system in an efficient and cost-effective manner.

(2) Acute care institutions should provide referral arrangements which aid the institution in developing an appropriate response to the patient's needs.

(3) Leaders of area business, labor and political communities should be provided opportunities to understand the purpose and value of acute care institutions.

(4) Revisions to MAHSA's plan for acute inpatient care services will utilize community-wide input.

Impact

A greater degree of patient satisfaction will result.

7.000 HEALTH SYSTEMS PLAN—SUMMARY

7.100 The Health Systems Plan

The Mid-America Health Systems Agency has produced the area's first Health Systems Plan (HSP) under the

National Health Planning and Resources Development Act of 1974 (Public Law 93-641). The Plan describes the population of the eight-county Kansas City metropolitan area,[1] indicators of the area's health status, and its health care system.

The Plan then describes the *desired* health care delivery system and compares it with the *existing* system to identify needs and problems. The product of this process is a set of five-year goals, objectives and action steps to improve the health of area residents and the health care system that serves them.

The HSP is designed to be a comprehensive and integrated plan for the health and health care of area residents. The development of a complete HSP will require more than one year because of the wide range of content necessary. Selection of topic areas for the first year was based on the following factors:

(1) services that will be reviewed under state Certificate of Need laws;

(2) areas identified as special concerns in Chapter 2.000 of the HSP;

(3) availability of data and other planning resources.

Most of the identified concerns were addressed either in detail or an introduction was developed for future expansion. The development of a primary care service section, and the expansion and updating of the mental health, emergency care and rehabilitation sections of the Plan are essential for the production of a comprehensive HSP. MAHSA will give these areas high priority in its second-year planning efforts.

---

[1] Counties in MAHSA's service area are Johnson, Leavenworth, and Wyandotte in Kansas, and Cass, Clay, Jackson, Platte, and Ray in Missouri.

Each section of the Plan describes the desired health status or health service system characteristics for the area, compares that description with the existing and projected health status or health services, and establishes goals wherever problems are identified. The projections and goals have a five-year perspective—January 1978 through December 1982.

7.200 The Health Planning Process

Development of the Health Systems Plan followed federal guidelines and MAHSA planning policies to produce a document responsive to the needs and priorities expressed by the community and federal and state health planning authorities.

The planning process involved community task forces, including MAHSA Board members, community technical advisory groups, and MAHSA staff. The draft plans were reviewed by the community, both consumers and providers, and their comments were taken into account before final adoption of the HSP.

There will be a yearly update of the HSP and increasing community participation should result as consumers and providers become more aware of the Plan, the planning process, and as the Plan's content is expanded.

7.300 Health Systems Plan Content

7.310 *Health Status*

MAHSA's initial study of the health status of the area's residents indicates that the major problems apparent are chronic diseases and social problems. These problems are evident in the area's death rates and the Plan calls for educational programs, and primary and secondary prevention measures to reduce premature deaths due to vascular diseases, diseases of early infancy, accidents, influenza and pneumonia, and homicides. These problems are known to be

impacted more by changes in personal lifestyles than by traditional treatments.

The infant mortality rate of 15.2 deaths per 1,000 live births in the MAHSA area is considered higher than necessary and a goal has been established of 12.0 deaths per 1,000 live births by 1983 for any of the region's sub-areas or population groups. Education of parents and potential parents in pre- and post-natal health practices, and better service coverage are seen as the most immediately effective methods of reaching this goal. Particular target areas are identifiable, the most evident being the nonwhite population where the infant mortality rate is double the rate for the white population (25.7 deaths per 1,000 live births for nonwhite residents compared to 12.7 deaths per 1,000 live births for white residents).

7.320 *The Health Care System*

The major emphasis in the health systems section of this first Plan is on availability, accessibility and cost of services. The other health systems characteristics—quality, acceptability and continuity of care—also have been addressed as appropriate.

Health Education—The kinds of health problems identified in the health status analysis, and community interest expressed in expanded health education services, are addressed in the consumer health education component of Chapters 5.000 and 6.000. This component emphasizes the need for consumer education aimed at changing personal lifestyles and health service use behaviors that impede health maintenance. The Plan emphasizes the need to develop basic health promotion and maintenance programs, and to coordinate existing disease or health problem-specific education activities for persons of all ages in a variety of service settings. Early education, involving all parts of the public school system, is posited as an essential part of the desired system.

Maternal and Child Care—Two general problems are found in the area of maternal and child care. The first is insufficient use of prenatal care services by more than one-fourth of the region's obstetrical patients. This problem requires both the development of outreach prenatal clinics and the development of school and public education programs for prospective mothers and families.

The second problem is underutilization of area hospital obstetrical facilities, which has a detrimental effect on quality and increases costs. The Plan recommends a reduction in the number of hospital obstetrical services from the existing 25 units to no more than 16 units by 1983.

Acute Inpatient Care—The acute inpatient care system in the service area is found to be meeting the service needs of area residents. The major problems found in this area center around coordination of services. Problems exist with respect to using the most economical level of service consistent with medical necessity, and with excess capacity of acute care services. There will be an estimated surplus of 800 to 2,400 acute care beds by 1983. The extent of the surplus, as explained in the Plan, will be dependent upon the rate of growth of the population and the utilization rate of hospital services.

The problems in acute inpatient care services are significant contributors to the problems of increasingly high hospital and overall health care costs.

The HSP's goals, objectives and recommended actions for acute inpatient care call for more cost effective delivery and use of hospital services through limiting inpatient capacity; encouraging use of alternative services; increasing integration of all health services; and educating consumers in the appropriate selection and use of acute care services.

Diagnostic Radiology—Computed Tomography (CT) scanners are the only topic addressed in this component.

The cost of CT equipment and the personnel necessary to use them effectively are significant enough that the number of CT scanners in the area must be held to the absolute minimum necessary to make CT services available and accessible to area residents. The Plan calls for limiting the number of full-body CT scanners in the area to 10 and placing such equipment only in hospitals that can be expected to fully utilize it and that provide a full range of treatment services (generally hospitals with 300 or more beds).

Emergency Medical Services—The activities of the Mid-America Regional Council Emergency Rescue (MARCER) system directed toward coordination of existing communication and transportation services for emergency medical care provide a basis for identification of service gaps and accessibility problems in subsequent Plan updates.

Mental Health Services—Determination of service needs and lack of coordination within the mental health services and between mental and other health services are found to be the major problems in the area's mental health care delivery system. Recommendations call for mechanisms to promote better coordination and for increased efforts to define service needs more specifically.

Rehabilitation Services—A preliminary examination of area rehabilitation services was done for this first Health Systems Plan and will be expanded as the Plan is revised yearly. Although evidence is not yet conclusive, there is reason to believe that continuity of care problems and financial barriers may be preventing many persons from receiving needed services. As such unmet needs are documented, the adequacy of available service capacity will be reassessed.

Long-Term Care—There is a projected shortage of approximately 1,750 long-term care beds in the MAHSA area by 1983. In addition to the need for beds there is also a

shortage of services in some existing homes. A number of homes in 1974 did not meet desired quality standards. There are problems with continuity of care, particularly in placing patients in homes providing the appropriate level of care. These continuity problems may have been due to financial accessibility barriers.

The five-year actions outlined in the HSP call for increased availability of services, improved quality of care, and a financing system that increases access to appropriate levels of care for area residents in need.

7.400 Health Systems Plan Conclusions

The overall indications of MAHSA's study of the health status of area residents and the health care system that serves them are: (1) that the most effective method of improving health is by reducing behavioral risk factors (smoking, overweight, early teen pregnancies, etc.); (2) that the outcomes of effectiveness and cost effectiveness of medical care services could be most improved by better coordination of health services to provide more appropriate utilization of services; and (3) that cost control measures are necessary in medical services and that more funds should be allocated to non-medical health services.

8.000 PRIORITIES FOR ANNUAL IMPLEMENTATION PLANS

The Health Systems Plan covers a five-year time frame and implementation will be programmed over that period in a series of five Annual Implemention Plans. Priorities are assigned on the basis of the scope and importance of the goal, the stage of development of the service, and the stage of development of the Plan. The priorities indicate the emphasis to be placed on the service or goal over the five-year period, but not necessarily the order in which developmental activities will occur.

8.100 First Priority Items

8.110 *Consumer Health Education*

The potential impact on health and cost of health care to be realized from improved healthful lifestyles and more appropriate use of health care services is considered to be extensive but presently untested. The process of maximizing the effectiveness of existing resources for consumer health education should begin as soon as possible. As this coordination and redirection of efforts progresses the need and potential gain from increased resources directed to this area can be determined. Implementation of the Plan's consumer health education component thus has a high priority and implementation will begin with the 1978 Annual Implementation Plan.

8.120 *Acute Inpatient Care Services*

Acute inpatient care services are the largest single component of the health care system. Measures to produce better coordination, more effective utilization, and to avoid excess capacity are a number one priority for implementation. The HSP actions for acute inpatient care services will be initiated beginning with the 1978 Annual Implementation Plan.

8.130 *Mental Health Services*

Chapter 2.000 indicated that federal, state and local concern over mental health problems and services make this area an important problem. This HSP does not contain a fully developed mental health services component. Nonetheless, it is clear that coordination of mental health services and determination of mental health care needs, more effective service mechanisms, and more effective financing mechanisms are a number one priority item for the HSP. Elaboration and completion of this HSP component and the beginning implementation of the actions suggested in it will be included in the 1978 Annual Implementation Plan.

8.140 ***Primary Care Services***

A primary care component for the Health Systems Plan will be included in the 1979-1983 HSP and primary care implementation measures will be a part of the 1979 Annual Implementation Plan. These services are given a number one priority because of the federal and state priorities with which MAHSA worked and because primary care services were emphasized by local consumers.

8.150 ***Long-Term Care***

Long-term care services are placed in the first priority category because of consumer concern and the anticipated increase in need for services and cost of services. HSP actions will be included in the 1978 Annual Implementation Plan.

8.160 ***Ambulatory Surgery***

Ambulatory surgery services were not covered in the current Plan. A section on these services, determining need levels, will be included in the 1979-1983 HSP.

8.200 Second Priority Items

8.210 ***Maternal and Child Care***

The HSP actions for maternal and child care problems and services will be initiated in the 1978 Annual Implementation Plan. The overall area is considered a second-level priority, but it must be noted that aspects of this service area are covered under consumer health education, primary care services, and acute inpatient care services.

8.220 ***Emergency Medical Services***

The emergency medical services component will be developed in the 1979-1983 HSP. Upon completion of that component, AIP objectives and actions will be developed.

8.230 ***Rehabilitation Services***

Assessment of rehabilitation services and needs will be continued with the 1979-1983 HSP. Any required actions will be included in the 1979 Annual Implementation Plan.

8.240 ***Prevention and Detection Services***

A health status goal in this HSP necessitates AIP objectives and corresponding actions for immunizations. The overall area of prevention and detection as classified in Appendix C is given a second-level priority. This should not be confused with community health promotion and protection which has been given a higher priority under consumer health education, primary care and mental health. Various screening approaches to secondary prevention will be examined and placed in the priority system in subsequent Health Systems Plans.

8.300 Third Priority Items

8.310 ***Environmental Quality Management***

Problems in the area of environmental quality management are given a third-level priority for the 1978 Annual Implementation Plan. These problems are the direct responsibility of a number of planning and governmental agencies and therefore are not assigned a high priority for the 1978 Annual Implementation Plan. Environmental effects on health are an important part of the content of the consumer health education component of this HSP and will be addressed under those activities. The health status section of the HSP will be further elaborated. Health problems that are closely related to environmental factors will be addressed in future Annual Implementation Plans.

8.320 ***Diagnostic Radiology***

The actions recommended in this HSP for diagnostic radiology will be included in the 1978 Annual Implementation Plan.

APPENDIX D

HEALTH CARE COSTS

PREVIOUS PAGE WAS BLANK

APPENDIX D

Table 1

National health expenditure, by type of expenditure and source of funds, fiscal years 1974–76

[In millions]

Type of expenditure	Total	Source of funds					
		Private			Public		
		Total	Consumers	Other [1]	Total	Federal	State and local
	1976 [2]						
Total	$139,312	$80,492	$75,622	$4,870	$58,820	$39,863	$18,957
Health services and supplies	131,022	77,722	75,622	2,100	53,300	36,247	17,053
Personal health care	120,431	72,013	70,457	1,556	48,417	33,683	14,735
Hospital care	55,400	25,004	24,352	652	30,396	21,394	9,002
Physicians' services	26,320	19,718	19,700	18	6,632	4,884	1,748
Dentists' services	8,800	8,131	8,131		669	288	181
Other professional services	2,400	1,607	1,559	48	793	540	254
Drugs and drug sundries	11,168	10,144	10,144		1,023	550	474
Eyeglasses and appliances	1,920	1,806	1,866		114	61	53
Nursing-home care	10,600	4,744	4,706	38	5,856	3,417	2,439
Other health services	3,933	800		800	3,133	2,548	585
Expenses for prepayment and administration	7,336	5,709	5,165	544	1,627	1,322	306
Government public health activities	3,255				3,256	1,243	2,012
Research and medical-facilities construction	8,290	2,770		2,770	5,520	3,616	1,904
Research [3]	3,327	258		258	3,069	2,818	251
Construction	4,963	2,512		2,512	2,451	798	1,653
Publicly owned facilities	1,673				1,673	37	1,636
Privately owned facilities	3,290	2,512		2,512	778	761	17

	1975 [4]						
Total	$122,231	$71,361	$66,584	$4,776	$50,870	$34,126	$16,744
Health services and supplies	114,652	68,450	66,584	1,875	46,192	31,047	15,145
Personal health care	105,745	63,779	62,447	1,331	41,966	28,866	13,100
Hospital care	48,224	21,690	21,146	544	26,534	18,371	8,163
Physicians' services	22,925	17,217	17,202	15	5,708	4,170	1,538
Dentists' services	7,810	7,409	7,409	----	401	249	152
Other professional services	2,190	1,581	1,541	40	609	416	193
Drugs and drug sundries	10,269	9,416	9,416	----	853	454	399
Eyeglasses and appliances	1,785	1,679	1,679	----	106	59	47
Nursing-home care	9,100	4,086	4,054	32	5,014	2,917	2,097
Other health services	3,442	700	----	700	2,742	2,231	511
Expenses for prepayment and administration	5,954	4,681	4,137	544	1,273	1,040	233
Government public health activities	2,953	----	----	----	2,953	1,141	1,812
Research and medical-facilities construction	7,579	2,901	----	2,901	4,678	3,079	1,599
Research [3]	2,942	250	----	250	2,692	2,453	239
Construction	4,637	2,651	----	2,651	1,986	626	1,360
Publicly owned facilities	1,413	----	----	----	1,413	69	1,344
Privately owned facilities	3,224	2,651	----	2,651	572	556	16
	1974 [4]						
Total	$106,321	$64,809	$59,836	$4,973	$41,512	$27,499	$14,013
Health services and supplies	99,330	61,581	59,836	1,748	37,746	24,928	12,818
Personal health care	91,315	57,259	56,039	1,220	34,056	22,974	11,082
Hospital care	41,050	19,594	19,081	513	21,456	14,334	6,893
Physicians' services	19,742	15,083	15,069	14	4,659	3,363	1,296
Dentists' services	6,870	6,544	6,544	----	326	211	115
Other professional services	1,929	1,497	1,459	38	432	284	148
Drugs and drug sundries	9,416	8,684	8,684	----	732	400	331
Eyeglasses and appliances	1,674	1,583	1,583	----	91	50	41
Nursing-home care	7,470	3,649	3,619	30	3,801	2,277	1,524
Other health services	3,214	625	----	625	2,589	1,855	734
Expenses for prepayment and administration	5,483	4,325	3,797	528	1,158	995	164
Government public health activities	2,531	----	----	----	2,531	959	1,572
Research and medical-facilities construction	6,991	3,225	----	3,225	3,766	2,571	1,195
Research [3]	2,527	227	----	227	2,300	2,078	222
Construction	4,464	2,998	----	2,998	1,466	493	973
Publicly owned facilities	1,204	----	----	----	1,204	246	958
Privately owned facilities	3,260	2,998	----	2,998	262	247	15

[1] Includes spending by philanthropic organizations and for providing industrial in-plant health services.
[3] Preliminary estimates.
[3] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies excluded from "research expenditures" but included in the expenditure class in which the product falls.
[4] Revised estimates.

Source: Social Security Bulletin, April, 1977

APPENDIX D

Table 2

U. S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
WASHINGTON, D.C. 20212

CONSUMER PRICE INDEX FOR URBAN WAGE EARNERS AND CLERICAL WORKERS

KANSAS CITY, MO.-KANSAS

MEDICAL CARE--SERIES F

(1967 = 100)

YEAR	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	AVG.
1946													
1947	39.6	40.1	40.3	40.4	40.4	40.5	40.4			41.0			40.6
1948	42.4			43.7			43.8			44.5			43.7
1949	44.5			44.6			44.9			45.1			44.8
1950	45.0			45.3			45.3			46.7			45.8
1951	47.0			47.4			47.7			48.3			47.8
1952	48.9			49.2			51.0			51.0			50.3
1953	51.3			51.4			51.4			51.5			51.4
1954	51.7			58.3			58.6			58.6			57.4
1955	58.6			58.6			58.8			58.8			58.7
1956	58.8			59.5			59.5			64.5			61.1
1957	64.5			64.7			64.8			65.6			65.0
1958	65.8			65.9			73.1			73.1			70.0
1959	73.1			73.4			73.6			73.7			73.6
1960	74.0			74.5			75.4			75.1			74.8

1961	75.2		78.0		77.8		78.4		77.7		
1962	78.7		78.9		79.3		79.4		79.1		
1963	79.6		79.7		79.9		80.3		79.9		
1964	80.4		80.9		86.7		86.6		84.1		
1965	86.7		87.3		87.8		89.2		89.8	88.2	
1966		92.6		93.4		93.9		94.6	93.3		
1967		99.2		99.8		101.7		101.7	100.0		
1968		105.6		106.7		107.2		109.0	106.5		
1969		110.6		112.4		113.3		113.6	112.1		
1970		115.0		116.6		118.3		120.4	117.0		
1971		122.1		123.9		126.9		126.8	124.4		
1972		127.8		128.9		129.6		131.8	129.1		
1973		134.1		134.5		135.2		138.8	135.1		
1974		144.0		147.0		151.5		153.2	147.7		
1975		159.3		159.4		162.1		165.3	160.5		
1976		170.3		174.2		175.2		182.2	174.1		
1977											
1978											
1979											
1980											

APPENDIX D

Table 3

U.S. DEPARTMENT OF LABOR
BUREAU OF LABOR STATISTICS
WASHINGTON, D.C. 20212

CONSUMER PRICE INDEX FOR URBAN WAGE EARNERS AND CLERICAL WORKERS

KANSAS CITY, MO.-KANSAS

MEDICAL CARE SERVICES--SERIES M-4

(1967 = 100)

YEAR	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.	OCT.	NOV.	DEC.	AVG.
1966												93.1	.0
1967			98.9			99.7			102.1			102.3	100.0
1968			107.2			108.3			109.0			111.0	108.2
1969			113.0			114.9			115.9			115.9	114.5
1970			117.7			119.6			121.8			124.3	120.2
1971			126.1			128.5			131.9			131.5	128.9
1972			132.7			134.2			135.0			137.2	134.3
1973			139.9			140.5			141.2			145.5	141.1
1974			151.8			155.6			160.1			161.4	155.9
1975			168.3			168.1			171.4			175.0	169.6
1976			180.9			184.3			185.7			193.9	184.6
1977													
1978													
1979													
1980													

APPENDIX D

Table 4

HOSPITAL CARE

Year	Total Amount (Millions)	% of Personal Health Care Expenditures
1960	$ 8,499	37.4%
1965	13,152	39.3
1970	25,879	43.1
1974	41,020	44.9
1976	55,400	46.0

NURSING HOME CARE

Year	Total Amount (Millions)	% of Personal Health Care Expenditures
1960	$ 480	1.9%
1965	1,271	3.8
1970	3,818	6.4
1974	7,450	8.2
1976	10,600	8.8

Source:

Social Security Bulletin, February, 1975 and April, 1977

APPENDIX F

ACUTE INPATIENT CARE SERVICES DATA

PREVIOUS PAGE WAS BLANK

APPENDIX F
Table 1
EXPENSES AND ASSETS
MAHSA COMMUNITY HOSPITALS

Year	Expenses (in thousands) Total	%Inc.	Plant Assets (in thousands) Total	%Inc.
1971	$206,587	--	$147,665	--
1972	227,915	10.3	174,466	18.1
1973	259,802	13.5	177,070	1.4
1974	290,265	12.2	262,776	48.4
1975	337,813	16.4	365,286	39.0

*Does not include Leavenworth and Ray Counties
Source: Hospital Statistics, American Hospital Association, Various Years.

Table 2
AVERAGE PLANT ASSETS PER ADJUSTED DAILY CENSUS
MAHSA COMMUNITY HOSPITALS

Year	SMSA (Kansas Portion)	SMSA (Missouri Portion)	Total SMSA*	United States Metro Areas	United States Total
1971	$33,605	$27,802	$29,362	$28,802	$27,292
1972	38,105	31,960	33,560	32,133	30,467
1973	36,135	32,454	33,478	34,828	32,875
1974	81,718	34,321	46,773	37,428	35,443
1975	97,745	50,704	62,927	41,895	39,476

*Does not include Leavenworth and Ray Counties.
Source: Hospital Statistics, American Hospital Association, Various Years.

Table 3
STAFFING PATTERNS
MAHSA COMMUNITY HOSPITALS

	Total SMSA*	United States Metro Areas	United States Total
FTE Personnel/Bed	2.81	2.73	2.54
FTE Personnel/Adjusted Average Daily Census	3.17	3.12	3.00
Average FTE Annual Wage	$7,970	$9,048	$8,635

*Does not include Leavenworth and Ray Counties.
Source: Hospital Statistics, American Hospital Association, Various Years.

CK:elk
7/77

APPENDIX F
Table 4

ADMISSIONS, OCCUPANCY RATES, AVERAGE LENGTH OF STAY IN COMMUNITY HOSPITALS

	1971	1972	1973	1974	1975	Projected Number of Admissions Based on 1975 Admissions/1,000 1982[1]	1982[2]	1982[3]	Projected Number of Admissions Increase Based on 71-75 Trend 1982[1]	1982[2]	1982[3]
Number of Beds-HARSA											
Staffed	6,189	6,234	6,514	6,611	6,676						
Licensed					7,334						
Approved*						8,456	8,456	8,456	8,456	8,456	8,456
Total Admissions-HARSA	222,147	231,736	235,516	241,355	244,851	244,851	251,812	282,720	268,688	276,386	310,310
Admissions/1,000 Population											
HARSA	169.1	172.0	173.7	178.8	182.4	182.4	182.4	182.4	200.2	200.2	200.2
U.S.	146.2	147.5	150.9	155.5	158.0						
N. Central Region	NA	166.2	172.2	177.9	183.0						
Occupancy Rates											
HARSA (Staffed Beds)	78.7	78.4	76.3	77.0	76.4	60.3	62.0	69.6	66.2	68.1	76.4
HARSA (Licensed Beds)					69.5						
U.S.	76.7	75.4	75.7	75.6	75.0						
N. Central Region	72.4	70.8	71.4	71.5	70.9						
U.S. Metro Areas	79.3	77.9	78.0	78.0	77.4						

Average Length of Stay					
MAHSA	8.0	7.7	7.7	7.7	7.65
U.S.	8.0	7.9	7.8	7.8	7.7
N. Central Region	8.5	8.3	8.3	8.3	8.1
U.S. Metro Areas	8.3	8.1	8.0	8.0	7.9
Inpatient Days/1,000 Population					
MAHSA		1,337	1,354	1,376	1,396	1,502
U.S.		1,163	1,180	1,207	1,209	
N. Central Region		1,387	1,424	1,468	1,481	

• Currently Approved by Planning Agencies

1 Assumes no population growth 1975-1982 (1,342,100)
2 Assumes increase in population based on 1970-1975 trend (1,380,550)
3 Assumes MARC population projections (1,550,000)

Note: Admissions projected through year-end 1982.

Sources: Missouri Center for Health Statistics
Kansas Hospital Association
Missouri Hospital Director
Licensed Medical Facilities in Kansas
AHA Guide to the Health Care Field, 1971-1975
Hospital Statistics, AHA, 1971-1975

APPENDIX F

Table 5

CURRENT UTILIZATION RATES AND PROJECTED BED NEEDS MEDICAL/SURGICAL--PEDIATRICS--PSYCHIATRIC BEDS MAHSA HOSPITALS

Year	Medical/Surgical			Pediatrics			Psychiatric	
	Beds	Admissions	Inpatient Days	Beds	Admissions	Inpatient Days	Beds	Inpatient Days
1974	5,237	194,594	1,557,547	562	24,371	129,379		
Occupancy rate	81.5%			63.1%				
Average length of stay		8.0			5.3			
Inpatient days/1,000 population			1,575			358	576	126,522*
				602	25,261	123,218	75.7%*	
1975	5,261	191,525	1,575,702	56.1%				94*
Occupancy rate	82.1%				4.9			
Average length of stay		8.2				355		
Inpatient days/1,000 population			1,583					

	Approved Beds		Approved Beds		
1983	6,988	1,820,925	601	141,892	636
Occupancy rate	90%		75%		85%
Inpatient days/1,000 population		1,583		355	
Beds needed	5,543		518		469*
Surplus	1,445		83		167

*Inpatient days not available for 118 beds located at Independence Sanitarium (NE Jackson County MHC), Rainbow Unit, and Bethany Hospital. 1975 occupancy rates based on 458 beds. Beds needed by 1983 is understated based on inpatient days of 94 days/1,000.

Source: Missouri Center for Health Statistics
Kansas Hospital Association

CK:elk
7/77

APPENDIX F

Table 6

TOTAL HOSPITAL BEDS - EXISTING AND APPROVED - MAHSA AREA
May, 1977

Hospital	TOTAL BEDS		MEDICAL/SURGICAL (Incl. ICU/CCU)		ICU/CCU	PEDIATRICS		OBSTETRICS		PSYCHIATRIC		ALCOHOL	
	Exist.	Appr.	Exist.	Appr.	Exist.	Exist.	Appr.	Exist.	Appr.	Exist.	Appr.	Exist.	Appr.
Cass County	50	50	38	38	-	-	-	12	12	-	-	-	-
TOTAL-CASS COUNTY	50	50	38	38	-	-	-	12	12	-	-	-	-
Liberty	130	120	124	120	6	6	0	-	-	-	-	-	-
N. Kansas City	310	355	232	275	38	20	20	16	18	24	24	18	18
Excelsior Springs	48	48	44	44	3	-	-	4	4	-	-	-	-
Spelman	128	128	107	107	5	11	11	10	10	-	-	-	-
TOTAL-CLAY COUNTY	616	651	507	546	52	37	31	30	32	24	24	18	18
Ray County	63	63	53	53	-	-	-	10	10	-	-	-	-
TOTAL-RAY COUNTY	63	63	53	53	-	-	-	10	10	-	-	-	-
Truman East	75	84	38	47	-	-	-	14	14	9	9	14	14
Plaza	8	8	8	8	-	-	-	-	-	-	-	-	-
Baptist	378	401	348	367	42	30	34	-	-	-	-	-	-
Children's	167	167	-	-	8	167	167[a]	-	-	-	-	-	-
Downtown	40	40	40	40	-	-	-	-	-	-	-	-	-
Martin Luther King	100	100	100	100	8	-	-	-	-	-	-	-	-
K.C.C.O.M.	248	426	204	382	4	20	20	24	24	-	-	-	-
Truman Medical Center	213	308	189	284	21	-	-	24	24	-	-	-	-
Independence San.	233	257	167	167	15	18	30	16	25	21	24	11	11
Lakeside	167	167	138	138	10	15	15	14	14	-	-	-	-
MCI	105	210	90	190	8	-	20	15	0	-	-	-	-
Menorah	383	430	308	357	21	27	27	22	20	26	26	-	-
N.E. Osteopathic	27	-	24	-	5	-	-	3	-	-	-	-	-
Research	521	543	404	426	26	38	38	29	29	50	50	-	-
St. Joseph	238	300	216	262	8	-	18	22	20	-	-	-	-
St. Luke's	665	665	583	583	30	30	30	52	52	-	-	-	-
St. Mary's	359	385	287	315	18	-	-	32	30	40	40	-	-
Trinity	301	361	253	313	18	18	18	-	-	30	30	-	-

Park Lane	-	110	-	110	-	-	-	-	-	-	-	-	-
John Knox Geriatric[b]	-	60[b]	-	60[b]	-	-	-	-	-	-	-	-	-
TOTAL-JACKSON COUNTY	4,228	5,022	3,397	4,149	242	363	417	267	252	176	179	25	25
Gardner	25	25	25	25	-	-	-	-	-	-	-	-	-
Olathe	100	100	90	90	12	-	-	10	10	-	-	-	-
Shawnee Mission	308	373	202	288	16	38	20	25	22	43	43	-	-
Humana	-	400	-	355	-	-	20	-	25	-	-	-	-
TOTAL-JOHNSON COUNTY	433	898	317	758	28	38	40	35	57	43	43	-	-
Cushing	94	94	84	84	-	-	-	10	10	-	-	-	-
St. John	70	70	64	64	2	-	-	6	6	-	-	-	-
TOTAL-LEAVENWORTH COUNTY	164	164	148	148	2	-	-	16	16	-	-	-	-

APPENDIX F

Table 6 (Cont.)

Hospital	TOTAL BEDS Exist.	TOTAL BEDS Appr.	MEDICAL/SURGICAL (Incl. ICU/CCU) Exist.	MEDICAL/SURGICAL (Incl. ICU/CCU) Appr.	ICU/CCU Exist.	PEDIATRICS Exist.	PEDIATRICS Appr.	OBSTETRICS Exist.	OBSTETRICS Appr.	PSYCHIATRIC Exist.	PSYCHIATRIC Appr.	ALCOHOL Exist.	ALCOHOL Appr.
K.U.	513	782	366	632	48	74	59	23	29	50	62	-	-
Bethany	379	426	276	323	14	21	21	26	26	28	28	28[c]	28[c]
Providence/St. Margaret	350	400	310	341	20	28	33	12	26	-	-	-	-
TOTAL-WYANDOTTE COUNTY	1,242	1,608	952	1,296	82	123	113	61	81	78	90	28	28
TOTAL-COMMUNITY HOSP.	6,796	8,456[d]	5,412	6,988[d]	406	561	601	431	460	321	336	71	71
V.A.-K.C.	482	482	419	419	-	-	-	-	-	63	63	-	-
V.A.-Leavenworth	448	448	277	277	-	-	-	-	-	171	171	-	-
TOTAL-FEDERAL HOSPITALS	930	930	696	696	-	-	-	-	-	234	234	-	-
Western Mo.	178	178	-	-	-	-	-	-	-	178	178	-	-
Mid-Continent	37	37	-	-	-	-	-	-	-	37	37	-	-
Rainbow Unit	60	60	-	-	-	-	-	-	-	60	60	-	-
Crittenden	-	25	-	-	-	-	-	-	-	-	25	-	-
TOTAL-PSYCHIATRIC HOSP.	275	300	-	-	-	-	-	-	-	275	300	-	-
Rehabilitation Institute	40[c]	40[c]	-	-	-	-	-	-	-	-	-	-	-
TOTAL-SPECIALTY HOSPITALS	40[c]	40[c]	-	-	-	-	-	-	-	-	-	-	-
TOTAL-HOSPITAL BEDS	8,041	9,726[d]	6,108	7,684[d]	-	561	601	431	460	830	870	71	71

[a] 22 parental self-care units, 45 bassinets

[b] Not approved by Planning Agencies

[c] Non-Acute Care

[d] Includes 60 beds at John Knox Geriatric

CK:gjh
6/77

Source: Missouri Center for Health Statistics; Kansas Hospital Association; MARSA and MACHPA Project Review Files

APPENDIX F
Table 7
HOSPITAL BEDS BY SERVICE AND OCCUPANCY RATE
1975
MAHSA HOSPITALS

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
CASS CO., MO.															
Local Government															
Cass Co. Mem.	50	50	1,955	50	65.8	38	79.7	-	-	12	22.1	-	-	-	-
CLAY CO., MO.															
Local Government															
Liberty	130	130	4,653	130	64.7	124	64.2	6	75.1	-	-	-	-	-	-
North KC	355	257	11,134	257	84.2	197	89.5	20	58.9	16	49.2	24	85.4	-	-
Not-for-Profit															
Excelsior Sprgs	50	50	1,581	50	55.6	44	56.8	2	77.7	4	31.2	-	-	-	-
Spelman Mem.	128	128	5,536	128	75.8	107	78.0	11	(Inc. in Med. Surg.)	10	49.8	-	-	-	-
JACKSON CO., MO.															
Local Government															
Jackson County	84	75	2,808	75	66.5	42	55.5	-	-	14	77.8	9 10b	50.4 111.5	-	-
State Government															
Western Missouri Mental Health	178	178	6,832	178	68.4	-	-	-	-	-	-	178	68.4	-	-
Federal Government															
Veteran's Hosp.		482	9,752	482	79.8*	419	79.8	-	-	-	-	63	93.3	-	-
For Profit															
Doctor's	34	34	756	34	36.3	34	36.3	-	-	-	-	-	-	-	-
Plaza	8	8	422	8	77.0	8	77.0	-	-	-	-	-	-	-	-
Not-for-Profit															
Baptist Mem.	401	378	14,327	378	82.5	348	86.4	30	37.7	-	-	-	-	-	-
Children's Mercy	167	167	5,431	167	69.6	-	-	167	69.6	-	-	-	-	-	-
Downtown	40	40	960	40	54.6	40	54.6	-	-	-	-	-	-	-	-

Hospital Beds by Service and Occupancy Rate - 1975

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
JACKSON CO. (Con'd)															
Not-for-Profit															
Dr. M.L. King	100	100	2,321	100	57.2	100	57.2	-	-	-	-	-	-	-	-
KC Osteopathic	426	248	9,022	248	79.7	204	84.7	20	66.6	24	46.9	-	-	-	-
KC General	224	222	7,804	222	73.9	196	74.8	-	-	26	67.5	-	-	-	-
Indep. San.	252	252	9,274*	252	74.9*	176	80.9	30	48.9	16	57.6	30	NA	-	-
Lakeside	167	167	5,275	167	67.8	138	75.9	15	33.2	14	27.5	-	-	-	-
Med. Ctr. of Independence	110	110	5,850	110	77.0	83	81.9	10	(Incl. in Med. Surg.)	17	50.2	-	-	-	-
Menorah	383	347	13,238	347	81.9	272	86.8	27	57.7	22	63.1	26	71.8	-	-
NE Osteopathic	27	27	469	27	30.2	24	31.6	-	-	3	18.5	-	-	-	-
Rehabilitation Institute	40	40	207	-	-	-	-	-	-	-	-	-	-	40a	44.7
Research	521	521	19,072	521	88.2	404	92.5	38	37.8	29	104.3	50	82.6	-	-
St. Joseph	271	215	7,447	215	76.8	180	83.7	18	31.8	17	52.4	-	-	-	-
St. Luke's	665	665	24,926	665	81.9	583	84.4	30	53.8	52	70.5	-	-	-	-
St. Mary's	385	359	11,897	359	79.9	287	80.1	-	-	32	68.2	40	87.7	-	-
Trinity	361	301	9,239	301	80.7	253	83.7	18	43.8	-	-	30	77.2	-	-
RAY CO., MO.															
Local Government															
Ray Co. Mem.	63	63	1,740	63	46.9	53	53.0	-	-	10	14.3	-	-	-	-
JOHNSON CO., KS.															
For Profit															
Gardner Com.	25	25	966	25	51.3	25	51.3	-	-	-	-	-	-	-	-
Not-for-Profit															
Mid-Continent Psychiatric	37	37	276	37	64.6	-	-	-	-	-	-	37	64.6	-	-
Olathe Com.	100	99	4,573	99	71.1	89	72.9	-	-	10	55.0	-	-	-	-
Shawnee Mission	303	241	11,038	241	86.8	187	90.3	18	64.4	22	57.1	14	115.6	-	-
LEAVENWORTH CO., KS.															
Federal Government															
VA Hospital		448	5,775	448	88.3	277	89.7					171	86.0		

*does not include psychiatric

Hospital Beds by Service and Occupancy Rate - 1975

Hospital	Total Licensed Beds	Total Staffed Beds	Number Discharged	ACUTE CARE: Total Acute Staffed Beds	Total Acute Occup. Rate	Med-Surg. Staffed Beds	Med-Surg. Occup. Rate	Pediatrics Staffed Beds	Pediatrics Occup. Rate	Obstetric Staffed Beds	Obstetric Occup. Rate	Psychiatric Staffed Beds	Psychiatric Occup. Rate	NON-ACUTE: Other Staffed Beds	Other Occup. Rate
LEAVENWORTH CO. (Cont'd)															
Not-for-Profit															
Cushing Mem.	94	94	2,837	94	55.7	84	59.1	-	-	10	16.9	-	-		
St. John	71	70	2,761	70	62.4	64	62.3			6	62.8	-	-		
WYANDOTTE CO., KS.															
State Government															
KU Med. Center	550	513	19,479	513	80.1	328	88.1	80	70.8	55	43.0	50	83.2	-	-
Rainbow Center	60	60	NA	60	NA							60	NA		
Not-for-Profit															
Bethany	389	361	11,847	333	73.8*	257	92.3	20	75.2	28	51.0	28	NA	28b	NA
Providence-St. Margaret	400	369	14,761	359	78.9	292	86.9	42	40.3	25	51.5	-	-		

	Beds Licensed	Beds Staffed	Total Acute	Med-Surg.	Pediatrics	Obstetrics	Psychiatric	Rehab.	Alcohol Treatment
Community	7,334	6,676	6,648	5,261	602	474	301		38
Specialty	40	40						40	
Psychiatric	275	275	275	____	___	___	275	—	—
TOTAL-NON-FEDERAL	7,649	6,991	6,923	5,261	602	474	576	40	38
TOTAL-FEDERAL		975	930	696			234		

Note: NA = Not Available
Others = a - Rehabilitation, b - Alcohol Treatment

Source: 1975 Health Facilities Survey, Missouri Division of Health, 1976
1975 Kansas Hospital Association Study of Hospital Utilization and Patient Origin
Missouri Hospital Directory - Missouri Division of Health
Licensed Medical Facilities in Kansas - Kansas Department of Health & Environment

CK:VP:gjh
3/31/77

APPENDIX F

Table 8

DISTRIBUTION OF APPROVED HOSPITAL BEDS (1977) AND POPULATION (1975)
MAHSA COMMUNITY HOSPITALS

Geographic Area	Population		Hospitals		Approved Beds		Beds/1,000 Population
	Total	%	Total	%	Total	%	
Platte	37,900	2.8%	0	-	-	-	-
Clay	132,300	9.8	4	12.1%	651	7.8%	4.9
Ray	18,900	1.4	1	3.0	63	.8	3.3
Northland	189,100	14.0	5	15.1	714	8.6	3.8
Leavenworth	54,900	4.1	2	6.0	164	2.0	2.9
Wyandotte	177,900	13.3	3	9.1	1,608*	19.2*	9.0
Johnson	234,100	17.4	4	12.1	898	10.7	3.8
Jackson	638,400	47.6	18	54.6	4,962	59.1	7.8
Cass	47,700	3.6	1	3.0	50	.6	1.1
Total	1,342,100	100.0%	33	100.0%	8,396	100.0%	6.26

* Includes 782 beds at KUMC. As approximately 50% of KUMC patients are from outside the Region, beds for resident population would be 6.8/1,000 for Wyandotte County and 14.5% of approved beds.

Source: Missouri Center for Health Statistics
Kansas Hospital Association
MAHSA and MACHPA Project Review Files

CK:elk
7/77

APPENDIX F

Table 9

SELECTED COMMUNITY HOSPITAL INDICATORS, 1975

	KANSAS	MISSOURI (VI)	KANSAS (VII)	WEST NORTH CENTRAL (VI)	TOTAL UNITED STATES
BASIC INDICATORS					
NUMBER OF COMMUNITY HOSPITALS	33	147	145	806	5,875
NUMBER OF BEDS	6,676	25,328	12,685	95,655	941,844
AVERAGE HOSPITAL SIZE (BEDS)		172	87	119	160
PERCENT OF U. S. BEDS		2.69 %	1.35 %	10.16 %	100.00 %
HOSPITAL BEDS/1,000 POPULATION	Exist. 5.0 App. 6.3	5.3	5.7	5.8	4.5
PHYSICIANS/100,000 POPULATION		148	138	141	149
DEMOGRAPHIC AND ECONOMIC INDICATORS					
CIVILIAN RESIDENT POPULATION (000'S)	1,342	4,738	2,240	16,604	211,445
PERCENT OF U. S. POPULATION		2.2 %	1.1 %	7.9 %	100.0 %
PERCENT OF POPULATION 65 YEARS AND OLDER	9.7%	12.6 %	12.6 %	12.2 %	10.5 %
PERCENT OF POPULATION UNDER 14 YEARS OLD		22.3 %	21.9 %	22.8 %	23.2 %
PER CAPITA INCOME		$5,387	$5,968	$5,715	$5,834
UTILIZATION INDICATORS					
PERCENT OF U. S. ADMISSIONS		2.57 %	1.26 %	9.09 %	100.00 %
PERCENT OF U. S. INPATIENT DAYS		2.73 %	1.26 %	9.60 %	100.00 %
PERCENT OF U. S. OUTPATIENT VISITS		2.10 %	1.24 %	6.45 %	100.00 %
ADJUSTED INPATIENT DAYS PER CAPITA	* 1.62	1.64	1.60	1.63	1.38
INPATIENTS					
OCCUPANCY RATE	76.4 %	76.2 %	70.4 %	70.9 %	75.0 %
ADMISSIONS/1,000 POPULATION	182.4	181	187	183	158
AVERAGE LENGTH OF STAY (DAYS)	7.65	8.2	7.8	8.1	7.7
PERCENT OF POPULATION HOSPITALIZED ON AVERAGE DAY	.38 %	0.41 %	0.40 %	0.41 %	0.33 %
INPATIENT DAYS/1,000 POPULATION	1,396	1,486	1,454	1,490	1,218
OUTPATIENTS					
OUTPATIENT VISITS/1,000 POPULATION	* 995	844	1,054	741	902
OUTPATIENT VISITS/INPATIENT DAY	* .69	0.57	0.73	0.50	0.74
OUTPATIENT VISITS/ADMISSION	* 5.46	4.65	5.63	4.05	5.70
SURGICAL OPERATIONS					
SURGICAL OPERATIONS/1,000 POPULATION	* 98.3	84.9	85.8	83.0	78.8
SURGICAL OPERATIONS/ADJUSTED ADMISSION	* .48	0.42	0.42	0.41	0.44

APPENDIX F

Table 9 (Cont.)

SELECTED COMMUNITY HOSPITAL INDICATORS, 1975

	KANSA	MISSOURI (VI)	KANSAS (VI)	WEST NORTH CENTRAL (VI)	TOTAL UNITED STATES
OPERATING INDICATORS					
ANNUAL INPATIENT TURNOVER RATE	36.8	33.94	33.09	31.76	35.50
EXPENSES					
PER CAPITA HOSPITAL EXPENSES	$ 212.47	$191.84	$164.42	$176.52	$184.26
PER CAPITA HOSPITAL EXPENSES/PER CAPITA INCOME (%)		3.56 %	2.76 %	3.09 %	3.16 %
ADJUSTED EXPENSES/INPATIENT DAY	$133	$116.74	$102.49	$108.04	$133.81
ADJUSTED EXPENSES/OUTPATIENT VISIT		$20.86	$13.85	$20.55	$22.45
ADJUSTED EXPENSES/ADMISSION		$957.07	$795.67	$878.87	$1,030.49
PAYROLL EXPENSES/TOTAL EXPENSES (%)	52.0 %	52.28 %	52.82 %	53.20 %	53.01 %
EMPLOYEE BENEFITS/TOTAL EXPENSES (%)		5.46 %	5.63 %	5.59 %	6.30 %
ADJUSTED PAYROLL EXPENSES/INPATIENT DAY		$61.03	$54.14	$57.48	$70.93
ADJUSTED NONPAYROLL EXPENSES/INPATIENT DAY		$55.71	$48.35	$50.56	$62.88
REVENUE					
GROSS INPATIENT REVENUE/INPATIENT DAY	$102.60	$125.93	$108.33	$113.44	$142.00
GROSS OUTPATIENT REVENUE/OUTPATIENT VISIT	$19.67	$23.92	$15.65	$22.71	$25.88
GROSS INPATIENT REVENUE/ADMISSION	$703.78	$1,031.58	$840.59	$923.67	$1,094.04
NET PATIENT REVENUE/TOTAL REVENUE (%)	91.88 %	90.91 %	94.25 %	92.82 %	92.02 %
GROSS OUTPATIENT REVENUE/GROSS PATIENT REVENUE (%)	8.40 %	9.74 %	9.49 %	9.05 %	11.89 %
ASSETS					
NET PLANT ASSETS/BED	* $ 55,933	$33,232.52	$31,976.03	$29,172.79	$33,226.25
ALL OTHER ASSETS/BED	* 21,517	$15,883.09	$14,373.34	$12,918.66	$16,450.65
TOTAL EXPENSES/TOTAL ASSETS	* .56	0.74	0.62	0.73	0.83
PERSONNEL					
FTE PERSONNEL/BED	* 2.81	2.40	2.14	2.11	2.52
FTE PERSONNEL/ADJUSTED AVERAGE DAILY CENSUS	* 3.16	2.83	2.77	2.71	3.00
AVERAGE YEARLY FTE WAGE	* $ 7,970	$7,876.89	$7,135.99	$7,732.56	$8,635.25
HOSPITAL EMPLOYEES AS PERCENT OF TOTAL LABOR FORCE		3.39 %	3.14 %	3.31 %	3.01 %
FACILITY AND SERVICE INDICATORS					
INTENSIVE CARE UNIT BEDS/TOTAL BEDS (%)		4.96 %	3.76 %	4.41 %	4.79 %
LONG-TERM CARE UNIT BEDS/TOTAL BEDS (%)		1.86 %	6.59 %	7.09 %	3.17 %

* *SMSA only (does not include Ray and Leavenworth)*

Source: Selected Community Hospital Indicators, 1975, American Hospital Association

APPENDIX F

Table 10

TOTAL BED NEED/SURPLUS PROJECTIONS--1983
MAHSA COMMUNITY HOSPITALS

	1983 Bed Need Projections Based on: 1975 Inpatient Days (1,396/1,000) Occupancy Rate--85%		1983 Bed Need Projections Based on: Inpatient Days (1,502/1,000) Occupancy Rate--85%	
	Need	Surplus	Need	Surplus
1982[1]	6,039	2,417	6,498	1,958
1982[2]	6,212	2,244	6,684	1,772
1982[3]	6,974	1,482	7,503	953

APPENDIX F

Table 10 (Cont.)

TOTAL BED NEED/SURPLUS PROJECTIONS--1983
MAHSA COMMUNITY HOSPITALS

	1983 Bed Need Projections Based on: 1975 Admission Rate (182.4/1,000) Length of Stay--7.65 Occupancy Rate--85%		1983 Bed Need Projections Based on: Admission Rate (200.2/1,000) Length of Stay--7.65 Occupancy Rate--85%	
	Need	Surplus	Need	Surplus
1982[1]	6,036	2,420	6,625	1,831
1982[2]	6,209	2,247	6,815	1,641
1983[3]	6,971	1,485	7,651	805

[1]No population growth (1,342,100)
[2]Increase in population based on 1970-75 trend (1,380,550)
[3]MARC projections (1,550,000)

Total beds available by January 1, 1983 - 8,456
Inpatient days - 1,502 - projection based on 1972-75 trend
Admission rate - 200.2 - projection based on 1971-75 trend

CK:gjh
9/77

Exhibit A to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

AFFIDAVIT OF JERRY B. BUXTON

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

(Title omitted in printing)

STATE OF MISSOURI

COUNTY OF COLE, SS:

COMES NOW JERRY B. BUXTON, of lawful age, first having been duly sworn, and states as follows:

1. I am the Director of the Insurance Division of the State of Missouri and have personal knowledge of the matters set forth herein.

2. While Chapter 354, RSMo. (1973) authorizes the Division of Insurance to regulate certain limited aspects of the activities of health service corporations, including Blue Cross, Chapter 354 does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

3. No rule or regulation promulgated by the Division of Insurance pursuant to its statutory authority regulates, governs or controls any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

4. No Missouri statute authorizes the Division of insurance to regulate, govern, control or review Blue Cross contracts with Missouri hospitals or other institutional health care providers. The Division of Insurance does not and cannot regulate, govern or control the terms and provisions of such contracts, rates of or conditions of reimbursement by Blue Cross under such contracts, nor entry into or termination of such contracts.

5. Chapter 355, RSMo. (1969) as amended does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

6. Chapter 374, RSMo. (1969) as amended, including without limitation Section 374.190, RSMo. (1969) does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

7. Sections 375.930, et seq., RSMo. (1978) does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

8. Chapter 376, RSMo. (1969) as amended does not regulate, govern or control any aspect of contracts between Blue Cross and hospitals or other health care providers in Missouri.

9. No provision of any of the aforementioned Missouri statutes authorize the Division of Insurance to regulate, control, govern or approve any aspect of any contract between Blue Cross and any institutional health care provider in Missouri.

10. Chapter 354, RSMo. (1973) and the rule and regulations promulgated pursuant thereto relate primarily to contracts between Blue Cross and its individual member subscribers, but the Division of Insurance has no statutory authority or power to control Blue Cross individual member subscriber contract rates.

11. The Insurance Division of the State of Missouri does not regulate, govern or control the provision or delivery of health care services to the general public by any hospital, nor any activity of any Missouri hospital or other direct

provider of health care, including, without limitation, any aspect of any hospital contract with any third party payor.

Further affiant saith naught.

/s/ JERRY B. BUXTON
Jerry B. Buxton

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 1st day of August, 1978.

/s/ JACK K. RICHARDSON
Notary Public

My Commission Expires:

Sept. 19, 1981

Exhibit B to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

AFFIDAVIT OF HENRY MANDRO

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

(Title omitted in printing)

STATE OF MISSOURI

COUNTY OF COLE, SS:

COMES NOW HENRY MANDRO, of lawful age, first having been duly sworn, and states to the best of his knowledge and belief as follows:

1. I am the Director of the Missouri State Health Planning and Development Agency and have personal knowledge of the matters set forth herein.

2. While the Missouri State Health Planning and Development Agency has been conditionally designated under Public Law 93-641, The National Health Planning and Development Act, it is not designated as a state planning agency for purposes of 42 USCA § 1320a-1 (SSA 1122), nor is it designated as a state planning agency under any certificate of need law in Missouri pursuant to Public Law 93-641 (42 USCA § 300m-2).

3. No agency or entity in Missouri is or has been designated by any Missouri law to perform the duties and functions of a state health planning agency under Public Law 93-641 (42 USCA § 300m, et seq.).

4. Missouri's participation in the SSA 1122 Program under 42 USCA § 1320a-1 terminated June 30, 1976. Missouri does not now have nor has Missouri had since that date any contract with HEW under the SSA 1122 Program.

PREVIOUS PAGE WAS BLANK

5. Missouri does not have any certificate of need law nor any law requiring or providing for review and determination of need for new institutional health services proposed to be offered or developed within the state.

6. The Missouri State Health Planning and Development Agency does not now regulate, govern or control rates charged by Blue Cross of Kansas City to its individual member subscribers.

7. The Missouri State Health Planning and Development Agency does not now regulate, govern, control or review contracts between Blue Cross of Kansas City and its individual member subscribers.

8. The Missouri State Health Planning and Development Agency does not now regulate, govern, control or review the terms, provisions, rates of reimbursement, entry into or termination of any contract or agreement between Blue Cross of Kansas City and a Missouri hospital or other institutional health care provider.

Further affiant saith naught.

/s/ HENRY MANDRO
Henry Mandro

Subscribed and sworn to before me, a Notary Public in and for the County and State aforesaid, this 3rd day of August, 1978.

/s/ D. B. KAMMERER
Notary Public

My Commission Expires:

June 18, 1981

Exhibit C to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

PREREQUISITES FOR APPLICATION FOR ADMISSION AS A BLUE CROSS PARTICIPATING HOSPITAL

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

PREREQUISITES
for
APPLICATION FOR ADMISSION
as a
BLUE CROSS
PARTICIPATING
HOSPITAL

Blue Cross of Kansas City
3637 Broadway • Kansas City, Missouri 64141

Additional copies of these Prerequisites
are available on request from:
Blue Cross of Kansas City
3637 Broadway, Box 169
Kansas City, Missouri 64141

January 1, 1976

The Board of Trustees of Blue Cross of Kansas City, Missouri (hereinafter referred to as "Blue Cross") in accordance with the purposes set forth in its Articles of Incorporation, has approved the following Prerequisites upon which, after January 1, 1976, it will consider any application for a contract as a Participating Hospital.

These Prerequisites are stated in broad terms to cover basic and minimal requirements in an all-inclusive sense and from a service area point of view. The Prerequisites are declaratory, informational, solely, and are not contractual or invitational in any degree or respect.

The Prerequisites are for the purpose of:

1. Assuring hospitals which offer the area an adequate range of hospital care of high quality and at reasonable cost and which meet the stated Prerequisites and which hospitals thereafter apply for participation status.

2. Assuring Blue Cross subscribers that hospitals granted participating contracts reasonably may be deemed capable of meeting all contractual obligations as Participating Hospitals.

Blue Cross of Kansas City

PREREQUISITES

Blue Cross will be guided by the following Prerequisites in contracting with hospitals that apply for participation in its hospital service plan after January 1, 1976. However, in the interest of best serving Blue Cross subscribers and hospitals, Blue Cross reserves the right to determine in its own discretion those individual hospitals to which it may wish to tender Participating Hospital contracts. These Prerequisites do not apply to hospitals presently participating with Blue Cross.

I. APPROVAL, LICENSURE, AND CONTROL

A. The hospital shall be accredited by the Joint Commission of Accreditation of Hospitals. If in operation less than twelve months and not eligible for official accreditation, it shall present evidence satisfactory to Blue Cross of its ability to become accredited upon completion of twelve months of operation.

B. If a hospital is an osteopathic hospital, it shall be accredited by the American Osteopathic Association. If in operation less than twelve months and not eligible for official accreditation, it shall present evidence satisfactory to Blue Cross of its ability to become accredited upon completion of twelve months of operation.

C. The hospital shall be acceptable to the

medical society of the county in which it is situated. If the hospital is an osteopathic hospital, it shall be acceptable to the official osteopathic physicians association of the state in which the hospital is located.

D. The hospital must be a public hospital which has received approval from the appropriate planning agency.

E. The hospital shall comply with all applicable licensing requirements.

F. The hospital must be in actual operation.

G. The governing body of the hospital shall be responsible for the operation of the hospital, including but not limited to the quality of medical care. The governing body shall assure to Blue Cross its charges are reasonable and consistent with other similar hospitals in the community providing similar services.

H. The hospital shall be organized and staffed so as to insure accurate, complete and current maintenance of all financial and business records, and capable of promptly presenting complete financial reports as may be reasonably requested by Blue Cross. The hospital must agree to the use of a uniform classification of accounts system based on the accounting manuals of the American Hospital Association and shall have an effective system of cost accounting. The hospital shall have its certified public accountants furnish data to Blue Cross upon request.

I. The hospital shall agree to cooperate with Blue Cross in observing and fulfilling the requirements of the Member Hospital Contract and the By-Laws of Blue Cross.

J. The hospital shall not refuse admission or service to any person on the basis of race, creed, color, or national origin.

II. EVIDENCE OF NECESSITY

The hospital must meet a clearly evident need for health care services in its defined service area. Health care institutions and institutional services shall be approved, and/or if required by law, certified as necessary, by the designated planning agency or areawide health planning agency respectively; or, when effective, by the designated State Agency as provided for in Public Law 93-641, the "National Health Planning and Resources Development Act of 1974."

Blue Cross shall seek the recommendation of the appropriate health planning agencies concerning the need for the hospital, but final determination as to the tender of a contract by Blue Cross shall be at the sole discretion of Blue Cross. Because lack of knowledge by any applicant of this requirement shall not be considered sufficient reason for waiving it, community groups contemplating construction of new hospitals are urged to consult with Blue Cross, if they expect to apply for participation in the hospital service plan, at some time well in advance of actual construction.

Exhibit D to Suggestions of National Gerimedical Hospital in Opposition to Motions to Dismiss

ADMINISTRATORS NEWSLETTER
From Blue Cross of Kansas City

SPECIAL NEWSLETTER TO BLUE CROSS MEMBER HOSPITALS IN MISSOURI

(Filed in the United States District Court for the Western District of Missouri, Aug. 18, 1978)

Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions. It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.

In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursable by Blue Cross of Kansas City.*

Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

/s/ GARY L. IHDE

Gary L. Ihde
Vice President
Institutional Provider Affairs

GLI: lmb

July 21, 1976

Exhibit B to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital

APPROVAL PROGRAM FOR BLUE CROSS PLANS

(Filed in the United States District Court for the Western District of Missouri, Nov. 28, 1978)

BLUE CROSS ASSOCIATION
840 North Lake Shore Drive
Chicago, Illinois 60611

5/12/77

This booklet describes the official Approval Program for Blue Cross Plans. It supersedes all previously published statements.

As early as 1933, the concept of Prepayment for Hospital Care was endorsed and within several years thereafter a set of Approved Standards for Nonprofit Hospital Service Plans was adopted. The Approval Program has been in continuous operation ever since. During this period, on several occasions, the Approval Standards and their interpretations were strengthened and clarified.

The purpose of the Approval Program for Blue Cross Plans is to assure that standards of performance are maintained to protect the interests of the public.

The interests of the public are protected by standards which require a Plan—to include representatives of the public and hospitals on its policy-making governing board; to promote enrollment; to provide benefits which substantially cover the costs of hospital services; to achieve and maintain financial stability; to pay out at least 85 per cent of subscriber income in the form of subscriber services; to report to the public concerning its operations and its programs; to operate in such a manner that none of its net earnings shall inure to the benefit of any individual, and

to meet certain licensing requirements which permit the Plan to use the Blue Cross symbol and name which are registered by the Blue Cross Association.

Only those Blue Cross Plans which are approved by the Blue Cross Association have the right to use the words "Approved by the Blue Cross Association."

GENERAL PRINCIPLES

1. APPROVAL of the Blue Cross Association and the words "Approved by the Blue Cross Association" shall be determined by a Plan's adherence to the "standards" set forth in the following section.

2. THE INTEREST AND RESPONSIBILITY of contracting hospitals, that is, hospitals guaranteeing service, make it desirable that in addition to representatives of the general public, the Plan's governing board shall include representatives of such hospitals. It is also desirable that the medical profession be represented on the Plan's board.

3. ALL HOSPITALS IN EACH ENROLLMENT AREA that are qualified and equipped to provide the services in the Plan's subscriber certificate should have an opportunity to contract to provide these benefits. At least a majority of these hospitals should so contract. Equitable arrangements should be made for provision of benefits in non-contracting hospitals.

4. NO PLAN SHOULD BE GIVEN ORIGINAL APPROVAL whose territory does not comprise sufficient area and population to provide adequate spread of risk and efficient and economical management, with an adequate number of hospitals to assure service to subscribers.

5. PLANS SHOULD ARRANGE FOR SERVICE BENEFITS to members, rather than provide cash allowances for the purchase of hospital care.

APPROVAL STANDARDS FOR BLUE CROSS PLANS WITHIN THE UNITED STATES

1. ORGANIZATIONAL STRUCTURE

A Plan's corporate and administrative structure shall be consistent with its scope and functions, and shall be governed by a board composed of representatives of the public and providers of service.

Interpretation:

A. A majority of the Plan's governing board shall be representative of the public. A public member shall not be an employee of or have a financial interest in a health care facility or be a member of a profession which provides health care services.

B. The interests of any board member, officer, or employee of a Plan which may be in conflict with the interests of the Plan shall be disclosed to the Board.

2. AUTHORITY TO OPERATE

A Plan shall operate as a voluntary, nonprofit, community service organization.

Interpretation:

A. A Plan shall have defined community service objectives which it implements in its operations.

B. A Plan shall operate in conformance with its legal authority.

C. Trustees or board members of a Plan shall receive no remuneration for such service, nor shall any part of the net earnings of a Plan inure to the benefit of any individual.

3. BENEFITS TO MEMBERS

A Plan shall provide its members with benefits which substantially cover the costs of hospital services.

Interpretation:

A. A Plan shall cover, on behalf of all member patients, an average of not less than 75 per cent of the total amount billed for usual and customary hospital services rendered on an inpatient basis in multiple bed accommodations in contracting hospitals. There shall also be some provision for outpatient coverage.

B. A Plan shall have provided as subscriber benefits, a minimum average of 85 per cent of its earned subscriber income during the three-year period immediately preceding the current approval review.

C. A Plan's benefit shall be increased to keep pace with the development of expanded services in contracting hospitals, and to work toward comprehensiveness of benefits.

4. FINANCIAL RESPONSIBILITY

A Plan shall maintain a financial condition that adequately protects its subscribers as evidenced by reports which include a full statement of all direct and contingent liabilities as presented in an independent annual audit. A Plan's reserves should be sufficient to meet claim and operating expenses for a period of at least three months.

When a Plan's reserves are not sufficient to meet claims and operating expenses for at least three months, it shall produce satisfactory evidence to the Association that its financial policies are sound and that corrective action is being taken to achieve sufficient reserves.

5. Cost Containment Program

A Plan shall adopt and implement a cost containment program. Such program, incorporating those guidelines established by the Blue Cross Association Board of Governors, shall include a means to analyze relevant data concerning costs of health care, to make appropriate recommendations as to effectiveness and to submit reports as required to the Blue Cross Association. (Effective immediately (5/12/77) with compliance measured after January 1, 1978.)

6. Relationship With Individual Hospitals

A Plan shall have written agreements with at least 75 per cent of non-federal short-term hospitals registered by the American Hospital Association containing at least 75 per cent of these hospitals' beds in the Plan's service area, and the agreements shall include:

A definition of the responsibility of the Plan to the hospital with respect to frequency of hospital reimbursement.

A definition of the method of hospital payment.

A definition of the responsibility of the contracting hospital to the Plan with respect to servicing and guaranteeing service to members holding contracts for which the Plan assumes responsibility and the hospital's responsibility for the prudent use of its facilities and services.

A definition of the rights of the Plan and its contracting hospitals regarding the right of inspection of the records by the other party to the contract and a statement of the rights of either party to cancel or amend the contract.

Interpretation:

A Plan may adopt reasonable standards governing the acceptability of hospitals as contracting hospitals. In

the event a Plan's standards of acceptability are more stringent than the American Hospital Association standards for registration, a lesser percentage than 75 per cent may be used by the Blue Cross Association to determine compliance with this standard.

7. Accounting and Statistical Records

A Plan shall maintain such accounting and statistical records as may be reasonably required by the Board of Governors of the Blus Cross Association and shall submit such reports on the form and in the manner so prescribed.

8. Interplan Cooperation

A Plan shall participate in national programs, generally accepted by Plans.

Interpretation:

The continuing availability of hospital service benefits to large segments of the public without geographic restriction requires effective cooperation among Plans and their contracting hospitals.

9. Enrollment

A Plan's enrollment objectives shall be determined and results shall be evaluated at least annually.

Interpretation:

A. A Plan shall provide group and non-group enrollment opportunities to the people in its service area at least annually.

B. Responsibility for promotion and enrollment shall be vested in the salaried management of the Plan. An independent sales agency shall not be given responsibility for promotion and administration.

10. PUBLIC INFORMATION

A Plan shall conduct a continuing informational program to explain its functions, services, financing, and responsibilities to the public.

11. RELATIONSHIP WITH ORGANIZED GROUPS OF HOSPITALS

A Plan shall maintain close liaison with organized groups of hospitals in its area.

Interpretation:

A. The Plan representatives and the state or local hospital association representatives shall meet at least semi-annually to discuss matters of mutual interest.

B. A Plan shall participate in programs sponsored by organized groups of hospitals.

C. A Plan shall regularly exchange with organized groups of hospitals, statistical, financial or any other information of mutual interest.

12. LICENSED BY THE BLUE CROSS ASSOCIATION

A Plan shall be a licensee in good standing under an agreement with the Blue Cross Association which attests to the Plan's compliance with the standards for such licensure and permits it to use the Blue Cross symbol and name.

FAILURE TO MEET APPROVAL STANDARDS

If a Plan fails to meet the provisions of one or more of the foregoing standards, the Plan Approval Committee may recommend to the Board of Governors of the Blue Cross Association that such Plan's approval be terminated. If a Plan fails (a) to furnish such information in support of its application as may reasonably be required, or (b) to

comply with the foregoing standards, all within such period as the Board of Governors may deem reasonable, the Board of Governors may terminate its approval.

If a Plan's failure to comply with one or more of these standards results in its being notified that approval is to be withdrawn, it shall have the right, upon request to the Board of Governors of the Blue Cross Association, to present evidence of the extent to which circumstances prevent compliance.

APPROVAL REQUIREMENTS FOR ORGANIZATIONS OPERATING NONPROFIT BLUE CROSS PLANS OUTSIDE THE UNITED STATES

1. The governing board shall contain representation of the public and of hospitals from the area served.
2. No member of the governing board shall receive compensation for service as such.
3. No portion of the earnings remaining after the cost of administration has been satisfied shall inure to the benefit of any individual.
4. Subscribers shall have free choice of physician and hospital.
5. The Plan shall make available to the public benefits which shall cover at least 75 per cent of that portion of hospital expense which the Plan acknowledges it is in business to prepay.
6. Provision shall be made for benefits in out-of-area cases.
7. Finances shall not be comingled with those of any hospital.
8. No employee shall receive more than half of his compensation through commissions or on a production-fee basis.
9. Reports as to fiscal condition and membership status and such other reports as may reasonably be required shall be furnished to the Blue Cross Association upon request.
10. The Plan shall be a licensee in good standing to use the Blue Cross symbol and the words "Blue Cross."
11. The foregoing requirements shall apply except as they may be prohibited by law.

Exhibit F to Answers of Blue Cross Association to Interrogatories of National Gerimedical Hospital

COST CONTAINMENT APPROVAL STANDARD FOR BLUE CROSS PLANS AND IMPLEMENTING REQUIREMENTS AND GUIDELINES

(Filed in the United States District Court for the Western District of Missouri, Nov. 28, 1978)

Cost Containment Approval Standard

"A Plan shall adopt and implement a cost containment program. Such program, incorporating those guidelines established by the Blue Cross Association Board of Governors, shall include a means to analyze relevant data concerning costs of health care, to make appropriate recommendations as to effectiveness and to submit reports as required to the Blue Cross Association."

Cost Containment: Meaning

The term "cost containment" has been widely used for a number of years. To assure a common understanding of the intent of the Approval Standard, and related materials which follow, a brief description of the term is in order.

With respect to Blue Cross Plan operations, containment of costs has two dimensions: (1) savings which can be obtained through internal productivity and administrative efficiencies and, (2) savings and/or cost avoidance of benefit payments made to providers.

The Standard is not directed at the first dimension noted above, i.e. sound internal business practices, efficient and timely claims processing, prudent buyer concept and the like. BCA monitoring and evaluation efforts of this aspect of Plan cost containment have been in effect through the existing Plan Performance Standards and the Total Plan Review program.

PREVIOUS PAGE WAS BLANK

The Standard, therefore, pertains to the second dimension of cost containment, maximizing the value of subscriber premiums employed as benefit payments. This dimension has two components. The first relates to those Plan activities which primarily accrue savings to Blue Cross Plan subscribers as opposed to all purchasers of care. Examples of such activities are coordination of benefits, determination of other payer liability and establishment and maintenance of an appropriate price differential relative to other payers.

The second component of benefit payment containment efforts consists of those initiatives associated with the the broader social, rather than traditional insurer, objectives of the Blue Cross movement. Plan involvement in incentive provider payment systems, health planning, utilization review, health education and innovative health care benefit programs are examples of this second component—the "value added" by Blue Cross Plans. This is accomplished by working with providers, government and other external entities to effectively contain total health care costs while assuring reasonable access to quality health care.

Requirements to Meet the Standard

In order to determine compliance with the Standard, there are requirements which constitute the minimum Plan cost containment activities. Presented below, under the categories of "structural" and "programmatic," are requirements for all Blue Cross Plans.

Structural Requirements

1) A data base which measure and evaluates at least annually, based on historical trends, regional or other comparisons, etc., the following six indices:

Hospital Inpatient Cost/member
Hospital Inpatient Cost/admission
Hospital Admissions/1000 members
Hospital Patient Days/1000 members
Hospital Acute Care Beds/1000 population
Hospital Acute Care Bed Occupancy Rates

It is highly desirable that these indices representing total Plan area averages, and any others that the Plan determines meaningful (e.g., outpatient cost per member, outpatient visits/1000 members, FTE hospital personnel per patient day, professional ancillary costs per admission, etc.), be disaggregated in as much detail as practicable and useful (by individual hospital, diagnosis, geographic area, type of hospital personnel, type of acute care bed or service category, major account, etc.) to enable the Plan to adequately identify cost problems and plan, monitor and evaluate cost containment programs and activities as solutions to these problems.

In addition, each Plan should regularly collect data on the number of physicians per 1000 population (preferably by specialty) and analyze this information in concert with the above indices.

2) An annual set of quantified objectives related to at least each of the six indices.

3) A plan of action for each objective which describes those specific projects and activities (with corresponding resource requirements-administrative costs) designed to achieve the objectives.

4) A monitoring, reporting and evaluation system designed to measure progress of the action plan and achievement of the objectives.

5) An annual report to the Blue Cross Association which presents the objectives and action plan with estimated and actual results.

Programmatic Requirements

The following fundamental programmatic initiatives are required of each Plan:

1) An active program of fraud and abuse investigation.

2) An internal, multi-level claims utilization review screening, evaluation and reporting system with respect to medical necessity and appropriateness of hospital inpatient stays and services rendered.

3) Educational programs directed at individual subscribers, groups and providers stressing prevention of unnecessary and inappropriate use of health care services.

4) Active coordination of benefits and subrogration programs if legally possible; an active legislative goal of making such programs legally possible, if necessary.

5) An active program of subscriber benefit eligibility determination and identification of non-covered services which have been billed to the Plan.

6) Participation in selected health planning activities, such as Plan representation on health planning agency governing bodies and/or standing committees, Plan data support or technical consultation to agencies relative to health plan development, evaluation of specific provider capital projects, etc.

7) Periodic exploration of incentive approaches for paying participating hospitals, such as prospective payment systems.

Beyond the basic programmatic requirements listed above, there are a variety of other programs or processes that represent options for Plan consideration, based on its local circumstances. Presented below in three categories is a non-exhaustive listing of such processes. From a practical standpoint, a given process may be viewed as falling within more than one category. In addition, processes in

any given category may vary in terms of the extent of savings which accrue to Blue Cross subscribers versus other purchasers of care and the general public.

1) Processes that a Plan can undertake with generally little or no active participation and concurrence of the provider community. These processes will tend to neither present direct and immediate economic risk for subscribers or providers, nor require contractual or legislative changes:

   —Internal analysis and comparison of available cost-price information on providers, from a reasonableness/efficiency standpoint;

   —Initial feasibility study of innovative benefit programs which bear some potential for cost containment, e.g., home care, second opinion surgery, ambulatory/same day surgery, preadmission or early testing, etc.;

   —Initial feasibility study of alternative delivery system programs, such as HMOs.

2) Processes that a Plan can undertake which require fairly active participation and acceptance by the provider community or subscribers, but which will tend to neither present direct and immediate economic risk for subscribers or providers nor require contractual or legislative changes, e.g.;

   —Utilization review educational/consultative support programs for providers, such as sharing UR profile information related to patterns of practice for individual hospitals and physicians compared to their peers;

   —Latter stages of planning and development of HMOs, prospective or other incentive payment features, or innovative health care benefit programs;

—Front-end consultative assistance to individual providers or geographic groupings of providers relative to their development of long-range institutional plans or specific capital project or service change proposals;

—Voluntary initiatives to reduce existing excess provider operating capacity, such as joint Plan/provider task forces to identify the nature and extent of excess capacity by type of service and geographical area and to study means, including financial and other considerations, towards its reduction or elimination;

—Provision of management consulting services, such as management engineering, to individual providers;

—Development and implementation with providers of patient health education programs.

3) Processes that a Plan can undertake which require a high level of concurrence by the provider community or subscribers and which tend to present economic risk for providers or subscribers, usually necessitating contractual or legislative changes;

—Negotiation and enforcement of contract provisions related to medical necessity and appropriateness of services rendered, guaranteed/non-guaranteed UR status, and/or hold-harmless programs;

—Negotiation and implementation of provider UR concurrent review contractual program requirements;

—Negotiation and enforcement of health planning conformance clauses in provider contracts or reimbursement agreements;

—Negotiation and implementation of prospective or other incentive payment agreements with providers;

—Testimony on proposed certificate of need legislation relative to such issues as providers, capital expenditures, and service changes to be covered, parties permitted to appeal CON decisions, legal sanctions for noncompliance with CON decisions, etc.;

—Testimony or statements at health planning agency public hearings, or appeals, related to specific provider capital project proposals;

—Negotiation and implementation with providers of alternative delivery system such as HMOs;

—Study and negotiation with providers of a differential pricing arrangement based on the Plan's appropriate share of an institution's economic costs;

—Negotiation and implementation of provider risk management programs related to malpractice coverage;

—Design and implementation of any cost-sharing features, e.g., deductibles or co-payment, in subscriber benefit programs.

To the extent practicable, ways of measuring the success or impact of these processes will be suggested by the Blue Cross Association (e.g., dollars and days of claims identified as misuse and/or denied in the claims UR screening program; portion of HSAs in the Plan area where the Plan is represented on governing bodies and/or key standing committees, unnecessary provider capital expenditures avoided as a result of Plan positions in health planning agency review or appeals processes, etc.)

Implementation of the Approval Standard

It is recognized that Plans must have sufficient time to meet all the requirements specified in this document. While effective immediately, compliance will be measured after January 1, 1978 as part of the Annual Approval Program.

The Blue Cross Association is developing a cost containment evaluation methodology/self audit manual as a guide to assist Plans as they develop their programs to comply with the Standard and accompanying requirements. The Association will also provide technical and consultative support upon request.

The Blue Cross Association's monitoring and evaluation of Plan compliance will utilize the following mechanisms:

1. The Approval Program for Blue Cross Plans.
2. The Total Plan Review program.
3. An integrated set of reporting requirements for Plans.

Exhibit J to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions of National Gerimedical Hospital Opposing Summary Judgment

AFFIDAVIT OF DAVID J. MASCHGER

(Filed in the United States District Court for the Western District of Missouri, Oct. 22, 1979)

(Title omitted in printing)

STATE OF MISSOURI,

COUNTY OF JACKSON, SS:

COMES NOW DAVID J. MASCHGER, of lawful age, first having been duly sworn, and states as follows:

1. I am the Administrator of National Gerimedical Hospital, d/b/a Lee's Summit Community Hospital and am authorized to make this Affidavit on its behalf.

2. National Gerimedical Hospital regularly purchases medication and other hospital supplies from numerous sources outside the State of Missouri.

3. National Gerimedical Hospital's primary financing has been obtained through a national bond issue underwritten by B. C. Ziegler and Company, West Bend, Wisconsin 53095.

4. National Gerimedical Hospital regularly receives third party cost and charges reimbursement from numerous sources outside the State of Missouri.

5. The day to day business of National Gerimedical Hospital is managed pursuant to a management contract by HCA Management Company, Inc., a division of Hospital Corporation of America, One Park Plaza, Nashville, Tennessee, a national and international hospital management firm.

6. National Gerimedical Hospital is a short term acute care facility which regularly offers and has regularly provided to date health care to Missouri and out-of-state patients.

7. Physicians on the medical staff of National Gerimedical Hospital have and continue to experience difficulty admitting their Blue Cross patients who are unwilling to accept admission to National Gerimedical Hospital because it is not a Blue Cross participating hospital.

8. Members of the general public have avoided and continue to avoid admission as patients at the National Gerimedical Hospital because it is not a Blue Cross participating hospital.

9. Individual Blue Cross member subscribers actually receive less Blue Cross reimbursement and have less Blue Cross coverage for medical care provided by National Gerimedical Hospital than they have for identical medical care received at a Blue Cross participating hospital.

I have read the above and foregoing and the information therein set forth is true and correct according to my best knowledge, information and belief.

Further affiant saith naught.

/s/ David J. Maschger
David J. Maschger

Subscribed and sworn to before me, a Notary Public in and for said County and State, this 23rd day of October, 1979.

/s/ Janice B. Thompson
Notary Public

My Commission Expires:
Feb. 22, 1983

Exhibit K to Response of National Gerimedical Hospital to Order to Show Cause and Preliminary Suggestions Opposing Summary Judgment

LETTER FROM GARY L. IHDE TO NATIONAL GERIMEDICAL HOSPITAL

(Filed in the United States District Court for the Western District of Missouri, Oct. 22, 1979)

3637 Broadway
P.O. Box 169
Kansas City, Missouri 64141

March 27, 1978

Mr. Gunter H. Stein
Administrator
National Gerimedical Hospital and
Gerontology Center
P.O. Box 767
Lee's Summit, Missouri 64063

Dr. Mr. Stein:

The Blue Cross Board of Trustees has reviewed your amended application for a Member Hospital Contract, as included in correspondence from James Beck dated February 15, 1978. The Board of Trustees also reviewed the letters of support for the institution as appended to the above referenced application.

After deliberation, the Board of Trustees voted unanimously at the Blue Cross Board meeting of March 21, 1978 to deny Blue Cross Member Hospital status to the National Gerimedical Hospital and Gerontology Center because your institution did not receive approval through the health planning process. As we had discussed with you prior to the submission of the application, health planning approval is a stated prerequisite as contained in the booklet, "Prerequisites for Application for Admission

as a Blue Cross Participating Hospital," and must be complied with prior to receiving Member Hospital status.

We will discuss this action by the Board with you should you desire.

Sincerely,

/s/ GARY L. IHDE
Gary L. Ihde, Vice President
Institutional Provider Affairs

GLI:mh

cc: James Beck
B. Kent Snapp

IN THE
UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

No. 78-0359-CV-W-3

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Plaintiff,

VS.

BLUE CROSS OF KANSAS CITY, *et al.*,
Defendants.

ORDER

(filed November 2, 1979)

On May 23, 1978, plaintiff, National Gerimedical Hospital and Gerontology Center (hereinafter referred to as National Gerimedical) filed a complaint against Blue Cross of Kansas City and Blue Cross Association alleging violations of the antitrust provisions of state and federal statutes.

Count I of the complaint alleges that the defendants and various named co-conspirators have engaged in a conspiracy in restraint of trade in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Plaintiff alleges in Count II that the defendants engaged in a continuing combination and conspiracy to boycott National Gerimedical in violation of § 1 of the Sherman Act, 15 U.S.C. § 1. Count III alleges that defendant Blue Cross Association and Blue Cross of Kansas City and their co-conspirators have combined and conspired in a continuous combination and conspiracy to boycott plaintiff hospital and coerce all Blue Cross subscribers to refuse to deal with plaintiff, in violation § 1 of the Sherman Act, 15 U.S.C. § 1, Count IV alleges that the defendants' actions were an effort to control market entry and dictate terms of access to the health care services mar-

ket and constitute an unlawful abuse of monopoly power in violation of § 2 of the Sherman Act, 15 U.S.C. § 2. Counts V through VIII allege violations of similar provisions of the state antitrust laws, Missouri Revised Statutes § 416.031-1 through § 416.031-2.

On July 14, 1978, defendant Blue Cross Association and defendant Blue Cross of Kansas City filed motions to dismiss plaintiff's amended complaint. After considering the parties' suggestions in support and in opposition thereto, the Court refrained from deciding the issues raised by the motion to dismiss pending the Supreme Court's decision in *Group Life and Health Ins. Co.* v. *Royal Drug Co.* Subsequent to the Supreme Court decision in that case on February 27, 1979, the parties have briefed the issue of the application of that case to the present facts. The defendants base their motion to dismiss the federal causes of action on essentially four grounds: (1) The conduct complained of is exempted from the antitrust laws by the provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015; (2) the National Health Planning & Resource Act of 1974 impliedly repealed the antitrust laws where the challenged conduct is necessary to effectuate the purpose of the Act; (3) plaintiff's complaint does not allege any ultimate facts to support a claim that the defendants engaged in a conspiracy within the meaning of the antitrust laws; and (4) prepaid medical plans offered by not-for-profit corporations are not "trade or commerce" within the meaning of the Sherman Act. Additionally, the defendants argue that if the federal claims are dismissed for lack of jurisdiction, the Court should exercise its discretion and dismiss the pendent state claims.

In an order issued October 11, 1979, this Court indicated that because it was considering matters outside the pleadings presented by the parties, it would treat the motion to dismiss as one for summary judgment in accordance with Rule 12(b)(6) of the Federal Rules of Civil Procedure. The parties were given an opportunity to present additional

evidence or to oppose this action. All parties have indicated that they have no further evidence to present and do not oppose this treatment by the Court.

Rule 56(c) provides in part that summary judgment should be granted when:

> . . . the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

It is well established that in considering a motion for summary judgment, the Court examines the evidence not to decide issues of fact but to determine if any real issues exist. *Krupin* v. *United States,* 439 F. Supp. 440 (E.D. Mo. 1977); *Bazzano* v. *Rockwell International Corp.,* 439 F. Supp. 1167 (E.D. Mo. 1977). The existence of some disputed facts in a case does not necessarily preclude the Court from granting summary judgment. To preclude summary judgment, the disputed facts must be material and of the type that would affect the outcome of the litigation. *Hahn* v. *Sargent,* 523 F.2d 461, 464 (1st Cir. 1975). Where legal questions of statutory construction involving legislative history and policy are concerned, summary judgment is an appropriate mechanism for disposing of these issues. *Mobil Oil Corp.* v. *Federal Energy Adm.,* 566 F.2d 87, 91-2 (T.E. App. 1977).

The Eighth Circuit has consistently recognized that summary judgment is an extreme remedy which should not be granted unless the movant establishes his right to judgment with such clarity as to leave no room for controversy. *Ledwith* v. *Douglas,* 77-1463, (January, 1978); *Unlaub Co.* v. *Sexton, Inc.,* 77-1293 (8th Cir. 1977).

In considering this motion the Court must view the facts most favorably to the party opposing the motion and give that party the benefit of any reasonable inferences to be

drawn from the facts. *Ledwith*, supra; *Unlaub*, supra; *New England Mutual Life Ins. Co.* v. *Null*, 554 F.2d 896, 906 (8th Cir. 1977). From all of the pleadings the Court has reviewed, it would appear that there is no material dispute as to the following facts which are a summary of the essential allegations of plaintiff's complaint by Blue Cross of Kansas City:

1. Plaintiff is a Missouri not-for-profit corporation which will open a *new* hospital on or about July 30, 1978 (Paragraph 3, Complaint);

2. Defendant Blue Cross of Kansas City is a Missouri not-for-profit Health Service corporation which offers private individual and group health care reimbursement plans and programs to the general public in Missouri and Kansas, and which contract with member hospitals and other health service provides for the administration of its health care reimbursement plans (Paragraph 4, Complaint);

3. Blue Cross is a major provider of private health care plans in Western Missouri and Eastern Kansas (Paragraph 13, Complaint);

4. All acute general care hospitals except plaintiff in the Blue Cross service area have contracted with Blue Cross and thus are "participating" hospitals. (*Ibid.*);

5. Blue Cross reimburses its individual subscribers for 100% of all covered hospital services, by direct payment to the hospital, for services at a participating hospital (*Ibid.*);

6. Blue Cross subscribers receive payment for 80% of covered hospital services performed at a non-participating hospital, which reimbursement is paid directly to the subscriber, not the hospital (*Ibid.*);

7. Blue Cross denied plaintiff a participating Member Contract solely because plaintiff failed to demonstrate a need for its hospital (Paragraph 17, Complaint);

8. Among the "Prerequisites" for membership in Blue Cross, was the requirement that a hospital "meet a clearly evident need for health care services in its defined service area." (Paragraph 18, Complaint);

9. In order to determine "clearly evident need" Blue Cross designated Mid-America Health Systems, Inc. ("MAHSA") a not-for-profit, non-governmental organization, engaged in the voluntary evaluation of health care services in Missouri and Kansas as the agency to conduct "need review" (Paragraphs 6 and 18(a), Complaint);

10. Blue Cross will not contract with any hospital as a "participating member hospital without MAHSA approval of need" (Paragraph 18(a), Complaint);

11. MAHSA has no power to impose sanction to enforce its determinations nor to compel review (Paragraph 18(b), Complaint);

12. MAHSA has publicly stated that it will disapprove and not consider favorably the addition of any acute care hospital beds.

Plaintiff's answers to interrogatories clarify one point. National Gerimedical Hospital's initial application to become a Blue Cross member hospital was made October 4, 1977 and was amended and resubmitted on February 15, 1978. (See Plaintiff's answer to Interrogatory No. 9, Ex. D.) On March 21, 1978 National Gerimedical Hospital was denied member status because it had not received approval through the voluntary health planning process. National Gerimedical has indicated that it never sought review by Mid-America Health Systems Agencies. (See Plaintiff's

answer to defendant's interrogatory No. 16, Ex. F.) Thus this is not a situation where Mid-America Health Systems has refused to issue a certificate of need to National Gerimedical Hospital, but rather plaintiff is challenging the policy of Blue Cross requiring them to seek Mid-America Health Systems' approval.

Application of McCarran-Ferguson Act

§ 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012(a) and (b) provides in part:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . *Provided,* That, after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

In essence this Act has been interpreted to exempt the application of the antitrust laws from the business of insurance if it is regulated by the state and if the challenged action does not involve a boycott, coercion or intimidation. In determining the initial applicability of the McCarran-Ferguson Act, two questions must be answered: (1) are the defendants engaged in "the business of insurance" and (2) is the challenged conduct regulated by state law? In order for the activity to be exempt from the application

of the antitrust laws, both of the above criteria must be satisfied.

The briefs of Blue Cross of Kansas City and Blue Cross Association submitted in July of 1978 cited numerous case decisions holding that hospital-provider contracts are the business of insurance, regulated by state law, and thus exempt from application of the antitrust laws. Had the Court been deciding this issue prior to February 27, 1979, it would have adopted the rationale of these decisions and found that hospital payments and subscriber rates were so interrelated that Blue Cross contracts with hospitals were a part of the business of insurance. Additionally, the Court would have found that the requirements of state regulation of the business of insurance had been met. However, the Court believes that in light of the language used by the Supreme Court in *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 59 L.Ed.2d 261 (1979) the rationale of these earlier circuit opinions is no longer valid.

In *Royal Drug* eighteen owners of independent pharmacies sued Blue Shield of Texas. Blue Shield offers insurance policies on prescription drugs. If an individual covered by one of these policies utilizes a pharmacy which has entered into a "pharmacy agreement" with Blue Shield, the insured pays $2.00 and the remainder of the prescription price is paid by Blue Shield. If the pharmacy selected is a non-participating pharmacy and has not signed such an agreement with Blue Shield, the individual must pay the full price charged for the drug by the pharmacy. The insured can then obtain a reimbursement for 75% of the difference between the price charged minus $2.00. Under the agreement Blue Shield agreed to reimburse a participating pharmacy for the pharmacy's cost of acquiring the drug plus the $2.00 paid by the individual. Thus only pharmacies that could afford to distribute prescription drugs for less than the $2.00 markup could profitably participate in the plan. In determining if the contract between Blue Shield and the pharmacies was exempt from the ap-

plication of the antitrust laws because of the McCarran-Ferguson Act, the Court identified one of the primary elements of an insurance contract as the spreading and underwriting of the policyholder's risk. Petitioners in the *Royal Drug* case argued that these pharmacy agreements did involve the underwriting of risk. Although the Court recognized that some type of provider agreement will be necessary for the existence of a service benefit plan, the Supreme Court was unwilling to infer that because an agreement is necessary to provide insurance, it is also "the business of insurance." *Royal Drug,* supra at 270 ftn. 9. In rejecting this argument, the Court found:

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies, which serve only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations.
>
> • • • The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its policyholders. The agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."
>
> The Pharmacy Agreements are thus legally indistinguishable from countless other business arrangements that may be made by insurance companies to

keep their costs low and thereby also keep low the level of premiums charged to their policyholders. *Royal Drug*, supra at 269-270.

Another reason for rejecting the claim that these contracts involved the business of insurance was the fact that the contracts in the the *Royal Drug* case were not between insurer and insured but were separate contractual arrangements between Blue Shield and the pharmacies engaged in the sale and distribution of goods and services other than insurance. The Court stated:

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer. The manager of an insurance company is no different from the manager of any enterprise with the responsibility to minimize costs and maximize profits. If terms such as "reliability" and "status as a reliable insurer" were to be interpreted in the broad sense urged by the petitioners, almost every business decision of an insurance company could be included in the "business of insurance". Such a result would be plainly contrary to the statutory language, which exempts the "business of insurance" and not the "business of insurance companies." *Royal Drug*, supra at 271-272.

Defendants have attempted to distinguish the *Royal Drug* case on the grounds that the provider contract involved here contain the indispensable characteristic of insurance, i.e., the underwriting and spreading of risk. In support of this argument, the defendants suggest:

> Under the provider contract Blue Cross agrees to reimburse hospitals for services rendered to its subscrib-

> ers *only so far as current earned income will permit.* (Article IVA, Provider Contract). Unless provisions for all expenses and allocations to reserves have been each month, earned income cannot be used to pay hospitals (Article IVC, IVD). If Blue Cross does not have sufficient funds to pay benefit payments in full to hospitals, each of the provider hospitals is to receive only a portion of the benefit payments on a pro rata basis from Blue Cross. [pp. 3-4, Reply of Blue Cross of Kansas City To Supplemental Suggestions of National Gerimedical Hospital in Opposition to Defendants' Separate Motions to Dismiss filed April 9, 1979.]

Were the Court to agree with defendants' interpretation of the contract, it is doubtful if *Royal Drug* would be sufficiently distinguished to render its holding inapplicable. However, the Court's interpretation of the provider contract in this case is not totally in accord with the defendants. Atricle IVB does require reserves to be maintained by Blue Cross sufficient to provide for three months operating expenses and benefits for hospital services. After provisions for reserves have been made, benefit payments each month are to be made to the hospitals equal to the amount of benefits due for all claims processed by Blue Cross. If sufficient funds are not available, adjustment on a pro rata basis is to be made; however, Article 4D provides:

> D. If benefit payments to HOSPITAL for Hospital Service are reduced because of the application of Article IV, C above, BLUE CROSS agrees to pay pro rata the amount of such reduction to all hospitals as current earned income becomes available for such purpose.

Thus, the risk of nonpayment does not fall on the hospital as the defendants suggest, but payment is eventually to be made as funds become available on a pro rata basis.

Comparison of the Blue Cross provider contracts in this case and the Blue Shield pharmacy agreements in *Royal* have convinced the Court that no rational basis for distinguishing these contracts exist. Further, the language of the Supreme Court seems to clearly imply that such distinctions should not be drawn and would be looked on with disfavor.

> If agreements between an insurer and retail pharmacists are the "business of insurance," because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords. Such agreements would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to the "business of insurance companies". But that is precisely what Congress did not do. *Royal Drug*, supra at 281.

The Supreme Court went on to add:

> There is no principled basis upon which a line could rationally be drawn that would extend the McCarran-Ferguson Act exemption only to an insurer's agreement with providers of goods and services to be furnished to its policyholders—such as agreements with hospitals, doctors, lawyers and the like. But assuming that such a line could rationally be drawn, to hold that even such provider agreements are the "business of insurance" is to ignore the language and purpose of the Act not to exempt the insurance industry as such from the antitrust laws. *Royal Drug*, supra at 281.

Therefore, defendants' motions for summary judgment on the basis that the conduct in this case involved "the business of insurance" and is thus exempt from the antitrust laws under the McCarran-Ferguson Act must be denied.

Implied Repeal of The Antitrust Laws

Secondly, the defendants have moved to dismiss the federal causes of action on the grounds that the National Health Planning and Resource Development Act of 1974 impliedly repealed application of the federal antitrust laws in the instant case. The doctrine of implied immunity or implied repeal of the antitrust laws is a judicially created exemption from the application of the antitrust laws which has been utilized to resolve potential conflicts between federal or state regulatory schemes and the antitrust laws. The Supreme Court has indicated that implied immunity has been adopted and applied:

> [I]mplied immunity [has been found] in particular and discrete instances to assure that the *federal agency* entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.

A number of well established principles can be derived from cases that have considered this doctrine. First, any immunity from the antitrust laws should not be lightly implied and repeal by implication is not favored. *Gordon* v. *New York Stock Exchange*, 422 U.S. 659, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975); *U.S.* v. *American Telephone & Telegraph Co.*, 427 F. Supp. 57 (E.D. La. 1976). In considering a claim of implied repeal of the antitrust laws, the Court should first attempt to reconcile the operation of the antitrust laws and the regulatory statutes. *Essential Communication* v. *American Telephone & Telegraph*, 446 F. Supp. 1090 (D.N.J. 1978). If reconciliation is not possible, for the reason that a clear repugnancy exists between the statutes or the particular provisions at issue and the antitrust laws, then an exemption may be created; however, the antitrust laws should be repealed only to the extent necessary to make the regulatory statute effective and then only

to the minimum extent needed. *Gordon, supra* at 479. *Mount Hood Stages* v. *Greyhound,* 555 F.2d 687 (9th Cir. 1977); *Oahu Gas Service, Inc.* v. *Pacific Resources, Inc.,* 460 F. Supp. 1359 (D.Ha. 1978); *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 385 (S.D. N.Y. 1976); see Application of Federal Antitrust Laws as Affected by Other Federal Statutes or the Federal Constitution, Annotation 45 L.Ed.2d 841.

After determining a conflict exists, the Court must also consider the manner in which Congress envisioned the conflict to be resolved. Therefore, the Court is faced with two issues in determining the effect of the National Health Planning and Resource Development Act of 1974. First, is there a conflict between this legislation and the antitrust laws. Secondly, how should that conflict be resolved.

In resolving the first issue, the Court must examine the 1974 National Health Planning and Resource Development Act. This Act was essentially composed of four parts: First, National Health Planning and Development, 42 U.S.C. § 300k through 300n-5; second, assistance for construction and modernization of health facilities; third miscellaneous provisions on the transition to the new program; and fourth, the Radiation, Health & Safety Act of 1974 amending the Public Health Service Act in this area. See Volume 4, U.S. Code Cong. & Adm. News (1977) p. 7842. The only portion of the Act with which the Court is concerned in this case is Subchapter XIII entitled "National Health Planning and Development".

The National Health Planning and Development portion of the Act established national health priorities. The Secretary of HEW was directed to issue guidelines concerning national health planning goals after considering the national health priorities established by Congress in this section of the Act. Two goals that were established by the Act and of special concern to Congress as evidenced in the

Act and in its accompanying legislative history were: (1) reduction of hospital costs; and (2) elimination of unnecessary duplication of health care facilities. The Secretary was also directed to set standards concerning the appropriate supply, distribution and organization of the nation's health resources. See 42 U.S.C. § 300k-1 through 300k-2. The National Advisory Council on health planning and development was established to advise and consult with HEW and to make recommendations to that department concerning the development of appropriate guidelines. 42 U.S.C. § 300k-3.

The Act provided for the establishment of health service areas in accordance with a number of very specific requirements set forth in 42 U.S.C. § 300*l*. To service these areas, health systems agencies were to be established in each health system area. These agencies were given responsibility for health planning and resource development in their particular area. 42 U.S.C. § 300*l*-2(b). Each health systems agency was to adopt a health service plan and an annual implementation plan. The functions assigned to the health service area were to effectuate the purposes of: (1) improving the health of the residents of their area; (2) increasing accessibility, acceptability and quality of the health services provided in their area; (3) restraining increases in the cost of health care; and (4) preventing unnecessary duplication of health resources. 42 U.S.C. § 300*l*-2. Procedures were also established for a state health planning and development program. The Act further provided that to implement the health service plan and the annual implementation plan, the Health Service Agency should seek the assistance of individuals, public and private entities, in its health service area. See 42 U.S.C. § 300*l*-2(c)(1). It thus appears that the Act authorized and anticipated that the health service agency established by its provisions would consult and work with private health care providers to attempt to achieve voluntary cooperation with the goals of the agency and of the Act.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act and conditionally designated as the health planning body for the eight county bi-state area encompassing the counties of Cass, Clay, Jackson, Platte and Ray in Missouri and Johnson, Levenworth and Wyandotte in Kansas. In November of 1977 Mid-America Health Systems established a health systems plan for 1978 through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at p. 6-19.)

The goal in this area was recognized as:

> *Goal:* Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at p. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> *Objective #4*
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at p. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at p. 6-22.)

The certificate of need requirement voluntarily adopted by Blue Cross of Kansas City seems to be authorized by the Act as well as the implementation plan of MAHSA.

In determining if an exemption to the antitrust laws can be implied, courts have distinguished two types of exemptions—specific and blanket. A specific repeal of the antitrust laws implies an exemption only for particular conduct or activity. An exemption for an entire legislative scheme would be a blanket exemption. Courts that have upheld claims of implied repeal have normally limited this repeal to the specific conduct challenged in that particular case; however, in the circumstances of this case defendant's claim is that the entire concept of the National Health Planning and Resource Development Act presupposes non-application of the antitrust laws so that any activity authorized and within the scope of that Act is free from antitrust challenges. The proper issue in this case then is whether there is a plain repugnancy between the scope of the National Health Care Planning and Development Act and the antitrust laws. Another formulation of this same test of somewhat easier application is whether an exemption to the antitrust laws is necessary to make this statutory scheme effective. The Court believes the answer is yes. In the Court's view, voluntary cooperation of the entire health care industry, including third party payors, is essential to the success of the Act.

The National Health Planning and Resource Development Act clearly attempted to set forth health care goals and a regional administrative framework within which achievement of these goals could be sought through cooperation and voluntary compliance with the health care industry. If the Court were to find that private business working in conjunction with the health system agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust law for their action, then the Court believes that the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

Having determined that a conflict exists, the Court must consider the method for resolving the discrepancy. The entire concept of the Act as well as the legislative history convinces the Court that the antitrust laws were not intended to apply to members of the health care industry clearly acting within the scope of the Act. In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. See *Essential Communities* v. *American Telephone & Telegraph*, 446 F. Supp. 1090 (D.N.J. 1978). The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Adm. News at p. 7878. In the Committee's view:

> The highly technical nature of medical services together with the growth of third party reimbursement mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's imme-

diate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Adm. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Adm. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Adm. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Adm. News at p. 7887.

Further, the Committee indicated:

> A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Adm. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

> Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.
>
> The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that

could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation. . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers, who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply

could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962-H11963.

A review of the Act and its legislative history compels this Court to concur with Representative Rogers' analysis of congressional intent in enacting the National Health Planning and Resource Development Act. It should be noted that congressional failure to include specific antitrust exemptions for the activities challenged in this case may in part be accounted for by the status of the case law in 1974. The majority of courts confronted with the issue at that time had held that third party reimbursement contracts came within already existing statutory exemptions under the McCarran-Ferguson Act. The fact that this exemption no longer applies in the instant case does not detract from the clear Congressional intent that activities in the health care area to reduce cost and eliminate duplication would not be subject to challenge under the antitrust statutes.

The defendants in support of their claim of implied repeal cite the March 2, 1979 decision of the United States District Court for the Eastern District of Michigan in *Port Huron Valley Hospital, Inc.* v. *City of Pontiac, et al.*, (attached as Exhibit C to the brief of Blue Cross of Kansas City filed April 9, 1979). A review of Judge Kennedy's opinion in *Port Huron* reveals that the existence of circumstances not present in this case were crucial to the reasoning and outcome there. In *Port Huron* the State of Michigan had adopted certificate of need legislation. Although such legislation is contemplated by the provisions of the National Health Care Planning and Research Development Act, *see* 42 U.S.C. 300m 1-5, Judge Kennedy's decision relied on the potential conflict between the state regulation and the federal antitrust laws. The Court does not view *Port Huron* as precedent for its decision in this case. However, it recognizes that the creation of an exemption from the antitrust laws where state certificate of need legislation is passed to insure compliance with the federal act and

application of the antitrust laws in instances of voluntary compliance with the federal act would be anomalous. Although not essential to the decision, the Court in *Port Huron* did find that the legislative history of the National Health Care Planning & Resource Development Act demonstrated congressional intent to at least partially repeal the antitrust laws. In fact Judge Kennedy found that it was the purpose of the Act to check the competition of the free market in the health services area. The Court would concur in this assessment of the Act.

On the basis of the factors outlined above, the Court finds: (1) a clear repugnancy exists between the National Health Care Planning & Resource Development Act and the antitrust laws; (2) Congress intended that action taken pursuant to the Act and clearly within the scope of the Act would be exempt from application of the antitrust laws. Therefore, the defendants' motion for summary judgment Counts I through IV on the grounds that the challenged conduct is exempt from the antitrust laws will be granted.

Two other issues were raised by the defendants which the Court will briefly discuss.

FAILURE TO STATE A CONSPIRACY CLAIM

Defendants characterize the statements concerning the conspiracy as conclusionary and maintain that these allegations are not supported by any allegations of material fact. To maintain a cause of action under § 1 of the Sherman Act a party must set forth the following allegations:

> (1) That the defendants contracted, combined, or conspired among each other; (2) that the combination or conspiracy produced adverse, anti-competitive effects within relevant product and geographic markets; (3) that the objects of and the conduct pursuant to that contract or conspiracy were illegal; and (4) that the plaintiff was injured as a proximate result of that

conspiracy. *Martin B. Glauser Dodge Co.* v. *Chrysler Corp.*, 570 F.2d 72, 81 (3rd Cir. 1977).

The Eighth Circuit has emphasized that the complaint need not set forth specific facts to support its general allegations. *Great Atl. & Pac. Tea Co.* v. *Amalgamated Meat Cutters & Butchers Workmen of North American Local No. 88*, 410 F.2d 650, 652 (8th Cir. 1969). The Court finds that judged by these standards the conspiracy allegations are sufficiently detailed to meet the above requirements and the complaint is not subject to dismissal for failure to allege ultimate facts supporting this theory.

The defendants also argued that sufficient facts are not alleged to demonstrate a boycott within the meaning of § 2(b) of the McCarran-Ferguson Act. Even if the business of insurance regulated by the state is involved so that generally the antitrust laws are inapplicable to a particular activity, an exception to this general rule is created by § 2(b) of the McCarran-Ferguson Act for concerted activity constituting a boycott, coercion or intimidation. Defendants had argued that even if the Court found that the business of insurance regulated by the state was involved, this exception mandated application of the antitrust laws. The issue of whether plaintiff has alleged sufficient facts to demonstrate that the boycott provisions of § 2(b) apply need not be reached since the Court finds that the exemption of the McCarran-Ferguson Act for the business of insurance does not apply.

INTERSTATE COMMERCE REQUIREMENT

Finally the defendants have moved to dismiss the complaint on the grounds that prepaid medical plans offered by not-for-profit corporations are not trade or commerce within the meaning of the Sherman Act. Section 1 of the Sherman Act provides in part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or com-

merce among the several States, or with foreign nations, is declared to be illegal. . . .

Restraint of trade or commerce is within the prohibition of the commerce requirement only if that restraint affects trade or commerce among the several states or with foreign nations. This effect on commerce requirement is therefore jurisdictional in nature and may be demonstrated in one of two ways. One formulation of the commerce requirement is the "flow of commerce" or qualitative test wherein the restraint complained of is placed directly on goods or services which are themselves in the flow of interstate commerce. Secondly, the requisite commerce requirement may be demonstrated by a quantitative test which involves transactions that although wholly intrastate substantially affect the flow of interstate commerce. See Von Kalinowski, 1 Antitrust Laws and Trade Regulations § 501[1]-[3].

Plaintiffs allegations appear to fall under the latter theory. Paragraph 15 of plaintiff's complaint states that National Gerimedical is one of the first hospitals in the United States specializing in health care services for the elderly. As such, it is intended to serve a national constituency through research and the development of improved health care for the aged. Involvement and effect on interstate commerce is alleged to exist because National Gerimedical is intended to service out of state patients, purchase drugs and supplies from out of state sources, receive income and make disbursements from out of state insurance, and receive out of state financing for construction and operation. Plaintiff's complaint further indicates that Blue Cross's denial of participating status will foreclose to plaintiff a significant portion of the health care market thus affecting the services rendered to out of state patients, the ability to purchase from out of state sources, and the utilization of out of state financing and insurance proceeds. While these allegations are not as specific as might be de-

sired, the Court finds that this issue is controlled by the decision in *Hospital Building Co.* v. *Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976). In Trustees of Rex Hospital plaintiff contended that defendant, a competing hospital, had conspired to restrain plaintiff's planned expansion of facilities in violation of § 1 and § 2 of the Sherman Act. Although the only contended effects on interstate commerce stemmed from plaintiff's provision of intrastate hospital services, the Court concluded that a substantial effect on interstate commerce had been alleged. The Court ruled:

> The complaint, fairly read, alleges that if respondents and their coconspirators were to succeed in blocking petitioner's planned expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out-of-state parent corporation would be less if the expansion were blocked. Moreover, the multimillion-dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish a "substantial effect" on interstate commerce under the Act. *Trustees of Rex Hospital, supra* at 343-4.

In reaching this decision the Court rejected an argument that the conduct is outside the scope of the Sherman Act because the effect on commerce is indirect and the conduct producing the effect not purposefully directed toward interstate commerce. Additionally, the Court found that an effect on commerce may be substantial under the Sherman Act even if its impact on interstate commerce falls far short

of causing enterprises to fold or affecting market prices. In the final analysis, allegations that:

> . . . fairly claim that the alleged conspiracy, to the extent it is successful, will place "unreasonable burdens on the free and uninterrupted flow" of interstate commerce, they are wholly adequate to state a claim. *Trustees of Rex Hospital,* supra at 345.

Defendants argue that prepaid medical plans are not trade or commerce and rely on *United States* v. *Oregon State Medical Society,* 343 U.S. 326, 72 S.Ct. 690, 96 L.Ed. 2d 978 (1951). In the Court's view, *Oregon State Medical Society* is not controlling the instant case. In *Oregon State Medical Society* it was alleged that the state medical association and local medical organizations had agreed not to compete in particular areas in offering their prepaid medical plans. The Court found that the sale of medical services through these prepaid plans was not trade or commerce. The challenged conduct here involves contracts or potential contracts between Blue Cross and the supplier of actual hospital services. Plaintiff's claim that the action complained of will affect the ability of National Gerimedical to provide the desired hospital services is indistinguishable from the effect that plaintiff's action was alleged to have caused in Trustees of Rex Hospital.

For the above reasons, the Court believes the allegations of the complaint establish that failure to obtain status as a "participating hospital" will have an effect on interstate commerce. Therefore, the defendants' motions for summary judgment on the grounds that the requisite effect on trade or commerce has not been alleged will be denied.

PENDENT STATE CLAIMS

Having determined that dismissal of Counts I through IV is appropriate, the Court must decide whether to retain the pendent state claims encompassed in Counts V through VIII. The Court recognizes that it has the power to decide

the state claims. The issue is one of discretion. In *United Mine Workers* v. *Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L. Ed.2d 218 (1966), the Supreme Court wrote:

> It has consistently been recognized that pendent jurisdiction is a doctrine of discretion, not of plaintiff's right. Its justification lies in considerations of judicial economy, convenience and fairness to litigants; if these are not present a federal court should hesitate to exercise jurisdiction over state claims, even though bound to apply state law to them. . . . Needless decisions of state law should be avoided both as a matter of comity and to promote justice between the parties, by procuring for them a surerfooted reading of applicable law. Certainly, if the federal claims are dismissed before trial, even though not insubstantial in a jurisdictional sense, the state claims should be dismissed as well.

Gibbs seemed to mandate dismissal of state claims where the federal claims were dismissed prior to trial. However, this aspect of *Gibbs* has been relaxed by subsequent Supreme Court cases. *See Rosado* v. *Wyman*, 397 U.S. 397, 90 S.Ct. 1207, 25 L.Ed.2d 442, 450-1 (1970).

Considerations of judicial economy, convenience and fairness to the litigants should be the determinative factors in deciding whether the Court should exercise its pendent jurisdiction or dismiss the State claims. See *Gibbs*, supra; *Rosado*, supra; *Blake* v. *Town of Delaware City*, 441 F. Supp. 1189, 1204-5 (D. Del. 1977). If hearings have been held in a case pending before the Court, discovery conducted and substantial work done towards preparing the action for trial, judicial economy might dictate retaining jurisdiction over the state claims. In this case however, no extensive discovery has been conducted on any issue other than the motion to dismiss and pending a ruling on the motion to dismiss, no answer has even been filed. Further,

the issues researched and briefed by the parties involve federal claims and no issues under the state claims have yet been addressed by the parties or the court; thus, judicial economy does not mandate the retention of the state law claims in this instance. Further, this is not a case where dismissal of the parties will leave the plaintiff without an adequate state forum. Therefore, fairness does not mandate retention in this case. Additionally, the factual situation set forth in plaintiff's complaint may involve unique applications of the state antitrust laws. The Court believes that state courts should be allowed to consider issues involving state antitrust laws which will undoubtedly be raised for the first time by this case. It is a well established principle that needless decisions of state law should be avoided as a matter of comity and to procure for the parties "a surefooted reading of applicable law." See *Gibbs*, supra; and *Euster* v. *Pennsylvania State Horseracing Commission*, 431 F. Supp. 828 (E.D. Pa. 1977).

For the above reasons, the Court believes that a proper exercise of its discretion necessitates dismissal of the pendent state claims.

For all of the reasons outlined above, it is hereby

ORDERED that defendants' motion to dismiss which has been treated as a motion for summary judgment is hereby granted and summary judgment is entered in favor of defendants and against plaintiff on Counts I through IV of plaintiff's complaint; and it is further

ORDERED that in the exercise of its discretion, the pendent state claims set forth in Counts V through VIII are also dismissed without prejudice.

RUSSELL G. CLARK, Judge
United States District Court

Dated: November 2, 1979

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

(Filed July 22, 1980)

Before STEPHENSON and MCMILLAN, Circuit Judges, and SACHS, *District Judge.

STEPHENSON, Circuit Judge.

The National Gerimedical Hospital, plaintiff-appellant, appeals from a summary judgment granted to defendant-appellee Blue Cross of Kansas City. National had charged Blue Cross and others [1] with violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The trial court [2] found Blue Cross' activities to be taken pursuant to Public Law 93-641, the National Health Care Planning and Resources Development Act of 1974, 42 U.S.C. § 300k, *et seq.;* that there was a repugnancy between the Act and the antitrust laws; and that consequently, under the doctrine of implied immunity, Blue Cross' activities were immune from

---

* The Honorable Howard F. Sachs, United States District Judge for the Western District of Missouri, sitting by designation.

[1] Blue Cross of Kansas City and Blue Cross Association were named defendant coconspirators. There were several non-defendant coconspirators listed in the plaintiff's complaint, including Mid-America Health Systems Agency, Inc. (MAHSA).

[2] The Honorable Russell G. Clark, United States District Judge for the Western District of Missouri.

the antitrust laws. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross*, 479 F. Supp. 1012 (W.D. Mo. 1979). We affirm the district court.

I. Statutory Background

The related health care statutes, as they existed during the relevant time period, are as follows.

Prior to the National Health Care Planning and Resources Development Act of 1974, the Public Health Service Act, 42 U.S.C. § 291, *et seq.* (known as the Hill-Burton Act) was the primary legislation channeling federal funds to states in support of construction and modernization of health care facilities. The Hill-Burton Act provides, as does much federal legislation involving state cooperation, for voluntary participation by the states. The participating state submits a state plan to HEW, which designates a particular state agency to be in charge of administering the state program and determining, *inter alia*, the need for new or expanded health care facilities. While an applicant could build without approval by the state agency, such applicant would not be eligible for reimbursement by the federal government. *Lakeside Mercy Hospital, Inc.* v. *Indiana State Board of Health*, 421 F. Supp. 193, 196-97 (N.D. Ind. 1976).

Other prior legislation providing for channeling federal funds into health care programs includes the Public Health Service Act § 314, 42 U.S.C. § 246 (amended 1978 and 1979). Under this program, federal funds are channeled to participating states that submit, and have approved by HEW, a Comprehensive Health Planning State Plan. This legislation provides for a state agency to be designated to screen health care applications in order to verify the need for new facilities and programs under the approved state plan, and also, in cooperation with the state agency, the Act provides for Area Comprehensive Health Planning Agencies, *Id.* at 197.

Section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (amended 1978 and 1979), enacted in 1972, provides for a participating state program for repayment provisions for Medicaid and Medicare, for which repayment prior to that time had not been dependent upon need approval by any of the various state health agencies (those designated by the state pursuant to compliance with federal requirements in order to be a participating state). Section 1122 of the Social Security Act authorizes HEW to enter into agreements with participating states whereby a state agency is designated as a health planning agency. This agency develops a state plan and makes recommendations as to the need of proposed expenditures for health care facilities, in conformity with regulations promulgated by HEW. Once final approval by HEW is received, the capital expenditure qualifies for purposes of reimbursement, via Medicaid and Medicare payments, the portion of fees allocable to return of depreciation, debt service and other capital related expenditures. *Id.*

The purpose of the National Health Care Planning and Resources Development Act of 1974, also providing for a participating state program, is "to facilitate the development of recommendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy." 42 U.S.C. § 300k(b).

Part B of the Act, 42 U.S.C. § 3001, provides for the establishment of health service areas and corresponding health systems agencies (HSAs). The purposes of the HSAs as stated in the Act include, *inter alia*, "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a). In order to accomplish its purposes, the HSA is to establish a health systems plan (HSP) and an annual implementation plan (AIP) which will achieve the goals of

the HSP. 42 U.S.C. § 300*l*-2(b)(2). The Act specifically provides that the HSA shall implement the HSP and AIP, and "*shall* seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1) (emphasis added). It is this section of the Act upon which the district court primarily rests its finding of antitrust immunity for the actions of Blue Cross.

II. Facts

Construction of the National Gerimedical Hospital began in August 1976 and was completed in September 1978. On October 4, 1977, Hospital submitted to Blue Cross a request for a member hospital contract. Pursuant to such contracts Blue Cross reimburses individual members the cost of all covered health services received at member hospitals. If health services are received by individual members at nonmember hospitals, Blue Cross individual members receive only up to eighty percent of the cost of the covered medical services. Also, for health services received at member hospitals, Blue Cross reimburses or pays the hospital for the services provided its individual members; with a nonmember hospital, the reimbursement is paid to the individual member, not to the hospital.

Blue Cross advised Hospital that Hospital must first secure need approval of Mid-America Health Services Agency (MAHSA) in order to be eligible for favorable consideration by Blue Cross for a member hospital contract.

MAHSA, named as a non-defendent alleged coconspirator,[3] is a private not-for-profit Missouri corporation engaged in voluntary health planning. MAHSA was conditionally designated an HSA under the Act and was notified of its designation for the eight county bi-state region of the metropolitan Kansas City area by letter from HEW

---

[3] *See* note 1 *supra*.

on April 7, 1976. *Mid-America Regional Council* v. *Mathews,* 416 F. Supp. 896, 899 (W.D. Mo. 1976). Thus during the relevant time period of this case, MAHSA enjoyed this status.

Prior to this time period, Missouri had participated in the Social Security Act § 1122 Capital Health Care Expenditures Program, which included a State Planning Agency that performed section 1122 program reviews, as discussed *infra.* 42 U.S.C. § 1320a-1 (amended 1978 and 1979). Blue Cross had required that large capital expenditures be approved by the local and regional planning arm of the section 1122 State Planning Agency before, *i.e.,* a hospital could be a member institute. This Capital Expenditure Program, as discussed *infra,* was designed to assure that federal funds appropriated for Medicaid and Medicare were not used to support unnecessary capital expenditures for health care facilities.

Area agencies established under 42 U.S.C. § 246 (amended 1978 and 1979), discussed *infra,* Area Comprehensive Health Planning Agencies (CHPs), were used in conjunction with the need approvals necessary under 42 U.S.C. § 1320a-1 (amended 1978 and 1979). The applicant for Medicaid and Medicare cost reimbursement had to seek a favorable recommendation from the CHP and secure a favorable determination of need from the state planning agency, the Missouri State Health Planning and Development Agency. The CHP for Missouri was MAHSA. The National Health Planning and Resources Development Act of 1974 gives preference to § 246 area agencies, CHPs and existing regional planning areas. 42 U.S.C. § 300*l*-4(b)(4) and § 300*l*(a)4.

On June 30, 1976, Missouri, a participating state under 42 U.S.C. § 1320a-1 (amended 1978 and 1979) since 1973, refused to renew Missouri's contract with HEW and Missouri's Program for Capital Health Care Expenditures was terminated.

On July 21, 1976, as reflected by a "Special Newsletter" to Blue Cross member hospitals in Missouri, Blue Cross gave notice that all projects in the Kansas City metropolitan area not reviewed and approved by MAHSA would not be reimbursible by Blue Cross of Kansas City.

> Blue Cross of Kansas City has been observing with considerable interest the events regarding the State of Missouri's cancellation of the SSA-1122 Capital Expenditure Program. It appears at this time that the final position of the Department of Health, Education, and Welfare on this matter has not been clarified with respect to reimbursement sanctions.[4] It also appears that the State of Missouri has no intention of reinstating the State Comprehensive Health Planning Agency to perform the SSA-1122 program review.
>
> In view of this action, the Provider Relations Committee of the Blue Cross Board of Trustees felt it necessary to advise all Missouri Member Hospitals of our position on this matter. As you are aware, the Member Hospital Contract contains a provision that capital expenditures of over $350,000 or 5% of the hospital's operating expense in the most recent fiscal year, whichever is lesser, be approved by the local or regional planning agency. Since the State Planning Agency no longer exists, Blue Cross of Kansas City will look to the local Health Systems Agency for approval of such capital projects. That Health Systems Agency in the Kansas City metropolitan area is the Mid-America Health Systems Agency and in the balance of our operating area, Area II Health Systems Agency. *All projects not reviewed and approved by these Health Systems Agencies will not be reimbursible by Blue Cross of Kansas City.*

---

[4] Appellant advises us that no question has been raised concerning Hospital's entitlement to full Medicare reimbursement.

> Therefore, we urge you to continue working with these agencies and Blue Cross of Kansas City in future planning needs for your hospital. Should you have any questions regarding our position on this matter, please do not hesitate to consult with us.

MAHSA was, of course, designated as the HSA under the Act. However, Missouri, during the relevant time period, had no law implementing the Act in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m.

MAHSA had publicly stated that it would disapprove and not consider favorably the addition of any acute care hospital beds; acute care hospital beds are the type Hospital provided; Hospital did not submit an application for need review to MAHSA; Hospital's application for a member contract with Blue Cross was denied in March 1978 by Blue Cross because Hospital had not received approval through the voluntary health planning process as required by the Special Newsletter. Hospital then filed this lawsuit.

III. Analysis

National argues that by requiring National to get need approval from MAHSA before it applies for a member hospital contract with Blue Cross, Blue Cross violates the antitrust laws. National contends that the requirement constitutes a contract, combination or conspiracy in restraint of trade, Sherman Act § 1, 15 U.S.C. § 1, and an abuse of Blue Cross' monopoly power in the private health care reimbursement plan market, Sherman Act § 2, 15 U.S.C. § 2.

What defeats National's otherwise appealing argument are the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation and assistance of private entities and persons in the community and health care market. While the doctrine of im-

plied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use.

The necessity of application of the doctrine of implied immunity arises if there is (1) a clear repugnancy between the antitrust laws and the specific conduct at issue and (2) if the intent of Congress is that implied repeal of the antitrust laws was intended. *Essential Communication Systems, Inc.* v. *AT&T*, 446 F. Supp. 1090, 1094-95 (D.N.J. 1978).

As to the first prerequisite, the district court herein stated its finding of repugnancy best when it stated:

> If the Court were to find that private business working in conjunction with the health systems agency established by the Act in their area to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then * * * the accomplishment of the purpose of the goals of the Act would be effectively foreclosed.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra*, 479 F. Supp. 1012, 1021 (W.D. Mo. 1979).

National's emphasis upon the fact that Missouri was not a participating state—"at all times here pertinent, Missouri had no law implementing P.L. 93-641 in Missouri nor designating any state agency thereunder in accordance with 42 U.S.C. § 300m" (brief for appellant at 12-13)—misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown*, 317 U.S. 341 (1943). The doctrine of implied immunity, in fact,

> is actually a subspecie of implied statutory repeal. *See, Gordon* v. *N.Y. Stock Exchange*, 422 U.S. 659, 682, 95 S.Ct. 2598, 45 L.Ed.2d 463 (1975), and *U. S.* v. *Southern*

Motor Carriers Rate Conference, 439 F. Supp. 29, 35 (N.D. Georgia, 1977). It is one of several distinct judicially created rules, which include "primary jurisdiction" and "exhaustion of administrative remedies", designed to resolve potential conflicts between two regimes with federal statutory authorization to regulate the conduct of business entities: federal administrative agencies and federal courts enforcing (among others) the antitrust laws.

The antitrust laws posit that the public interest is best served when business enterprises are compelled to compete in markets free of anti-competitive restraints. In contrast, the basic premise of administrative regulation is that the freedom of business entities must be in some degree curtailed to maximize the general welfare. When the same conduct falls within the scope of both the antitrust laws and a regulatory scheme, potential conflicts of competency and policy are resolved under the doctrine of implied immunity.

Essential Communication Systems, Inc. v. *AT&T, supra,* 446 F. Supp. at 1094 (footnote omitted). Missouri's lack of state participation did not affect the Act which set up a regulatory scheme which designated MAHSA as a regulatory need review agency. More specifically, it has no effect upon that portion of the legislation which calls for a regulatory system which included the designated HSA implementing the HSP and AIP "with the assistance of individuals and public and private entities in its health service area." 42 U.S.C. § 300*l*-2(c)(1).

The extent of this regulatory scheme is demonstrated by the district court's discussion.

Mid-America Health Systems Agency was one of 205 regional health systems agencies established under the Act * * *. In November of 1977 Mid-America Health Systems established a health systems plan for 1978

through 1982 in this region. Increasing hospital costs and unnecessary duplication of facilities and equipment were considered two of the biggest problems in this region. The health systems plan adopted by Mid-America Health Systems recognized:

> Problem—The acute inpatient care system does not function in a coordinated manner which is cost-effective in the delivery of acute care services at the most appropriate level consistent with quality standards. (Health Systems Plan at pp. 6-19.)

The goal in this area was recognized as:

> Goal: Improve the health of the population in the MAHSA area through an adequately available and accessible acute inpatient care system coordinated in a manner that fosters containment of health care costs and provides quality of care in a culturally acceptable manner. (Health Systems Plan at pp. 6-19.)

To implement this goal MAHSA established a number of objectives in this area and specified particular methods that could be utilized to achieve each objective. Objective No. 4 seeks to:

> **Objective #4**
>
> Maintain a rate of increase in total expenditures for hospital care services which does not exceed the rate of increase in the medical care services component of the Consumer Price Index. (Health Systems Plan at pp. 6-21.)

As one of the nine methods set forth to meet this goal, Mid-America Health System suggested:

> (6) Third party payors and the hospital community should work together to develop uniform reporting systems and procedures such that meaningful hospital-

to-hospital and year-to-year hospital cost and service-by-service utilization comparisons can be made. (Health Systems Plan at pp. 6-22.)

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1020-21. Implied immunity can be found in "particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws." *United States* v. *National Association of Securities Dealers, Inc.,* 422 U.S. 694, 734 (1975).

We agree with the district court's finding of clear repugnancy between the Act and the antitrust laws, as the Act and regulatory scheme clearly call for the action which has now become the basis of an antitrust claim.

We now examine the history of the Act in order to determine the congressional intent in regard to immunity. The district court concluded, after a thorough review of the legislative history, that it was the intent of Congress to immunize this type of voluntary action from the antitrust laws. We cannot improve on the district court's discussion:

> In essence the antitrust laws posit that the public interest will be served best when business enterprises are compelled to compete in markets free of anti-competitive restraints. * * * The concern of the Senate Committee that considered the health care legislation at issue here was the failure of the health care industry to "respond to classic marketplace forces." See Volume 4, U.S. Code Cong. & Admin. News at p. 7878, U.S. Code Cong. & Admin. News 1974, p. 7878. In the Committee's view:
>
> > The highly technical nature of medical services together with the growth of third party reimburse-

> ment mechanisms act to attentuate the usual forces influencing the behavior of consumers with respect to personal health services. For the most part, the doctor makes purchasing decisions on behalf of the patient and the services are frequently reimbursed under health insurance programs, thus reducing the patient's immediate incentive to contain expenditures. Volume 4, U.S. Code Cong. & Admin. News at p. 7878.

The Committee expressed concern over increasing hospital costs and improper utilization of existing facilities. Volume 4, U.S. Code Cong. & Admin. News at pp. 7893-4. The Committee in fact stated:

> The recent rapid acceleration in the costs of personal health services, far outstripping the rate of inflation in other sectors of the economy, has caused the Committee great concern. Although recognizing the increase in costs experienced by health care providers attributable to general inflation, the Committee wishes to express its concern with respect to the disproportionately high rate of increase in costs of health care services. Volume 4, U.S. Code Cong. & Admin. News at p. 7895.

The Committee attributed many of the cost and duplication problems in the health care industry to reimbursement programs like the ones these defendants sponsor. The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction. In summarizing the Act, the Committee stressed:

> The long-range goal plan is expected to provide for the prevention of unnecessary duplication of

resources and assure that quality health services will be available and accessible in a manner which assures continuity of care at reasonable costs for all residents of the area, and which is responsive to the needs and resources of the area. U.S. Code Cong. & Admin. News at p. 7887.

Further, the Committee indicated:

A health planning agency is directed to seek to implement its long-range goal plan and short-term priorities plan with the assistance of individuals and public and private entities in its health area. In so doing, the agency is directed to provide technical assistance, to the extent practicable, to such entities in bringing about consistency with its health plan. Volume 4, U.S. Code Cong. & Admin. News at p. 7888.

This interpretation of the legislative history is further supported by Representative Paul Rogers in debates over subsequent amendments to this Act. Representative Rogers expressed concern over interpretations of the National Health Planning and Resource Development Act of 1974:

Concern has been expressed that HSA's and health care providers who voluntarily carry out the mandates of the health planning laws (titles XV and XVI of the Public Health Service Act) may be in violation of the antitrust laws.

The antitrust laws prohibit actions which have the effect of restraining trade or competition. We have found, however, that there is minimal price competition within some parts of the health sector and that often the only competition is around the provision of services. One undesirable result of service competition has been that hospitals and

other health care providers have acquired duplicative and expensive equipment and facilities which have led to higher costs for the consumer. In enacting Public Law 93-641, which added Titles XV and XVI to the Public Health Service Act, the Congress made a specific judgment that control of the development of health care facilities was needed even though price and service competition might be restrained, and created a health planning system that could promote the efficient use of health resources through the regulation of and voluntary action by providers.

Title XV requires HSA's to bring together both consumers and providers to plan for an efficient health care system that will meet the area's needs. The HSA governing body is to make decisions in its health systems plan and in appropriateness [sic] review recommendations that affect market allocation . . . In doing so, the HSA may develop institution-specific recommendations; . . . or develop broader recommendations, such as, three cardiac catheterization laboratories in the area should be consolidated. In either case, it is congressional intent that providers and consumers work together in cooperation with the HSA to determine how best to carry out such recommendations. Without the voluntary cooperation of providers, the provision of title XV dealing with the development of a plan and the review of existing institutional health services could not be carried out.

. . . congressional intent was for the HSA, the provider seeking the certificate of need and other providers which might seek to provide similar services to coordinate their activities to assure that new institutional health services are developed in accordance with the health systems plan for the area.

> Although Public Law 93-641 contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. If they were, Public Law 93-641 simply could not be implemented. Congressional Record—House, No. 18 Part 1, p. H11962-H11963.

National Gerimedical Hospital & Gerontology Center v. *Blue Cross, supra,* 479 F. Supp. at 1021-23.

We adopt the district court's discussion, as set out above. We affirm the district court's holding; the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring Hospital to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract.

Appellee Blue Cross also argues that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, exempts the challenged conduct from the federal antitrust laws. We agree, in all respects, with the district court's holding that *Group Life & Health Insurance Co.* v. *Royal Drug Co., Inc.,* 440 U.S. 205 (1979) (defining "the business of insurance" in connection with the McCarran-Ferguson Act) controls. *National Gerimedical Hospital & Gerontology Center* v. *Blue Cross, supra,* 479 F. Supp. at 1016-19. Thus, we hold that the McCarran-Ferguson Act insurance exemption is not applicable in this case.

The district court is affirmed.

A true copy.

Attest:

CLERK, U.S. COURT OF APPEALS, EIGHTH CIRCUIT.

JUDGMENT

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER
Appellant,

v.

BLUE CROSS OF KANSAS CITY, BLUE CROSS ASSOCIATION,
Appellees.

APPEAL FROM the United States District Court for the Western District of Missouri.

THIS CAUSE came on to be heard on the original designated record of the United States District Court for the Western District of Missouri and briefs of the respective parties and was argued by counsel.

ON CONSIDERATION WHEREOF, it is now here ordered and adjudged by this Court, that the judgment of the said District Court, in this cause, be, and the same is hereby, affirmed in accordance with the opinion of this Court.

July 22, 1980

Costs taxed in favor of Appellee, Blue Cross Assn:

Costs of printing 10 copies of brief	$726.34
Total costs of Appellee, Blue Cross Assn., for recovery from Appellant in the U.S. District Court	$726.34

A true copy

ATTEST: ROBERT D. ST. VRAIN
Clerk, U.S. Court of Appeals, 8th Circuit

PREVIOUS PAGE WAS BLANK

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 79-2018

NATIONAL GERIMEDICAL HOSPITAL
AND GERONTOLOGY CENTER,
Appellant,

vs.

BLUE CROSS OF KANSAS CITY, et al.,
Appellee.

ORDER

The Court, having considered appellant's petition for rehearing and suggestions for rehearing *en banc* and being now fully advised in the premises, hereby orders the petition for rehearing and suggestions for rehearing *en banc* denied.

August 22, 1980

PREVIOUS PAGE WAS BLANK